INDEPENDENT RESEARCH PROJECT

Antony Collins BSc Hons

Exploring psychological processes in reflective practice groups in acute inpatient wards.

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Abstract

This critical review examines the research evidence relating to the effectiveness of reflective practice groups for staff in psychiatric inpatient settings, and the role of psychologically trained practitioners in providing facilitation using psychological formulations. Psychologically trained practitioners provide a valuable resource to inpatient services and this review investigated their specific contributions in supporting staff teams through the process of reflection. Models of reflection were explored in relation to experiential learning theory. Mentalization and Object Relations theories were reviewed to establish whether they could provide a theoretical understanding of the psychological components involved in developing reflective capacity. In reviewing the literature into reflective practice groups facilitated by psychologically trained practitioners, limited research on their use in psychiatric inpatient settings was found. Five studies were identified that specifically explored reflective practice groups on inpatient wards facilitated by psychologically trained practitioners using psychological formulations. The evidence suggested staff gained a better understanding of patients' difficulties, leading to enhanced staff patient relationships and increased perception of treatment efficacy. Currently no empirical research is available relating to how acute psychiatric staff process psychological understanding gained from reflective practice groups. The relevant studies have been reviewed and gaps in the literature identified.

1. Introduction

1.1 Acute Psychiatric Wards

Admissions to acute psychiatric wards provide an essential service during a critical time in a person's life. However, psychiatric inpatient wards are considered by service users to be non-therapeutic, restrictive and dangerous places, where the psychological needs of individuals are neglected (Quality Care Commission, 2009). The Sainsbury Centre for Mental Health (1998) and Mind (2000) reported concerns about the quality of care available to inpatients, and identified a desire from service users to have the option of psychological interventions whilst being treated on psychiatric wards.

The importance of providing a supportive and containing environment for the treatment of acute mental and emotional distress has long been recognised. In 1953, the World Health Organisation stated "the creation of the atmosphere of a therapeutic milieu is in itself, one of the most important types of treatment which a hospital can provide". They defined a therapeutic milieu as "providing a supportive and nurturing environment, where interpersonal relationships can develop to enhance positive interactions between staff and patients. A therapeutic milieu enhances levels of communication between service users and staff, thereby decreasing the impact of subjective emotional and mental distress". Penn et al., (2004) described the quality of relationships between psychiatric staff and inpatients as one of the main factors associated with recovery and relapse, whilst Oliver and Kuipers (1996) suggested a link to symptom reduction.

1.2. Key Policy Guidance

The National Service Framework (NSF) (Department of Health, 1999a) emphasized the need for inpatient care to meet the needs of service users by being therapeutic, educational and inclusive, providing an environment that promotes normalised interaction between staff and inpatients to facilitate the recovery process.

The Mental Health Policy Implementation Guide into Adult Acute Inpatient Care Provision (Department of Health, 2002) reported concerns including inadequate staff contact with patients, difficulties in maintaining therapeutic engagement due to staff pressures, and a lack of clarity and purpose for inpatient care. They suggested clinical psychology input needed to be increased to equip staff with the necessary skills to develop the inpatient therapeutic milieu. Key targets were established that aimed to outline the function and purpose of inpatient care within the national policy framework, including increasing staff's therapeutic levels of engagement with patients. The needs of staff were identified, with importance placed on enhancing their role and status through training and professional development. In addition, opportunities for reflective practice that "created a space for reflection, thinking and understanding and the thoughtful application of skills, knowledge and timely interventions" were also advised.

1.3. The Therapeutic Potential of Mental Health Nursing

Mental health nurses represent the largest professional discipline in acute psychiatric inpatient settings, making them well positioned to provide therapeutic input to patients (Gamble et al., 1994). Sullivan (1998) found nursing interaction with patients lacked a focused

therapeutic or theoretical foundation with “no well developed concept of nurse-patient interactions based on sound theory”. In relation to concerns regarding a lack of psychosocial interventions from staff in acute inpatient units, Cleary (2003) suggested staff lacked the necessary skills and knowledge, contributable in part to a lack of confidence, time pressures and staff not being involved in multidisciplinary communication forums. Carradice and Round (2004) found that although staff working in continuing care with people with severe and enduring mental health problems had good intentions, they lacked the necessary knowledge and understanding to deal effectively with challenging behaviour. This increased stress levels and reduced empathic capacity, resulting in continuing problematic behaviour and an institutionalized culture resistant to change and development.

In their review on practice development in relation to nurses working in inpatient settings, Carradice and Round (2004) advocated the use of models and theories from allied disciplines, for example, psychology, psychotherapy and counselling to enhance practice development. In developing a model for improved acute psychiatric inpatient care, the City Nurse Project (Flood et al., 2006) found staff’s ability to regulate their emotional reactions to patients, and displaying positive attitudes towards patients, contributed to low-conflict, high therapeutic wards. This was achieved by staff utilising organisational support, including clinical supervision, which allowed the development of their interpersonal skills, and improved team working.

Hinshelwood (2002) theorised that to cope with high levels of stress, nursing staff can become task driven and focused on symptom and risk management strategies. He found that

psychiatric staff responded to stress by reacting in an uncaring manner, limiting their exploration and understanding of patient's difficulties, leading to reduced empathy, with the result that patients are likely to have a negative experience of psychiatric admissions.

Evidently, acute psychiatric inpatient staff encounter a wide range of challenges in providing safe, therapeutic care and support to people experiencing severe and enduring mental health difficulties, and the negative impact of staff stress levels on patient care are of concern. However, there is evidence to suggest the development of a therapeutic focus within acute inpatient settings is attainable, leading to effective interventions and more positive outcomes for patients. The following section presents a review of the literature in relation to the theory and efficacy of reflective practice.

2. Reflective Practice

Within the health care professions the development of reflective practice skills are widely acknowledged as being important in developing effective clinical practice and expertise, role satisfaction (Department of Health, 1999b; Hargreaves, 1997; Sainsbury Centre for Mental Health, 2000), and in generating greater awareness and understanding of complex practice issues (McAndrews & Samociuk, 2003).

2.1. **Definitions of Reflective Practice**

A number of broad definitions of reflective practice can be found that encapsulate the range and scope encompassing both the educational and health care professions. The concept of reflection was first developed as an experiential learning process by Dewey (1933), who defined

the process of reflection as "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends" (p.9). Within health care settings, reflective practice has been defined as "intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations" (Bould, Keogh, & Walker, 1985; p.23). According to Mantzoukas and Jasper (2004), this enables practitioners to approach problems through a conscious process of structured thinking that results in the development of practice-based knowledge. This provides the basis for the critical examination of professional practice with the aim of developing key competencies, promoting practice-generated theories, and enabling practitioners to foster an understanding of complex phenomena (Clouder, 2000; Driscoll & Teh, 2001). Bennett-Levy (2003) has suggested that reflective practice is the key determinant in how individuals learn and develop their knowledge and skills base.

2.2. **Theories of Reflective Practice**

Schon (1983) identified two mechanisms of reflection; 'reflection on action', and 'reflection in action'. A decision taken in the moment and informed by previous knowledge and experience is a process underpinned by 'reflection in action'. This relates to the capacity to critically think about ones' own actions in the moment, where complexity and unfamiliarity are encountered, and when theory driven procedures have reached their limits. 'Reflection on action' occurs post-event, and allows the analysis of the event to enhance practice in the future. According to Schon, this can lead to a better understanding of practice and a means by which learning is developed through experience.

Schon (1983) proposed that reflection was crucial in learning because it linked theory and practice, enabling professionals to gain understanding and develop meaning from their experiences. Van Manen (1991) has suggested that 'reflection on action' can be used before an anticipated event, enabling practitioners to devise and implement strategies in a prepared manner. In professional practice, practitioners are commonly faced with the limitations of theoretical and scientific knowledge. Reflective practice assists practitioners in developing their skills and knowledge by incorporating practice-based theory, allowing for greater capacity in dealing with complexity and the uncertainties they face in day-to-day practice (Lavender, 2003).

Related to Schon's (1983) concept of 'reflection on action' is Kolb's (1984) experiential learning theory which suggests learning is "the process whereby knowledge is created through the transformation of experience" (p.41). The process of learning develops by reflecting on action and involves activation of an individual's thoughts, feelings and senses, whilst encompassing previous life experiences. This increases an individual's ability to conceptualise on an abstract level, and subsequent understanding and knowledge is amenable to experimentation, leading to new experiences and further reflection.

To obtain reflective capacity Atkins and Murphy (1993) suggested individuals needed to progress through three stages: self-awareness; critical analysis; and developing new perspectives. Roth and Pilling (2007) have suggested that clinicians who are regularly exposed to, and reflect on complex and novel challenges in their clinical practice develop higher-order competencies. This is akin to Schon's (1984) concept of 'knowledge in action', where conscious learning is

progressively internalised resulting in the development of unconscious skills and competencies (Steadman & Dallos, 2009).

Using the model of single-loop and double-loop learning processes proposed by Argyris and Schon (1978), Braine (2009) argued inadequate reflective teaching skills may expose recipients to single-loop as opposed to double-loop learning experiences. Single-loop learning functions within limited parameters, for example, by identifying problems and reflecting on solutions. Double-loop learning in contrast, involves consideration of a person's implicit and explicit assumptions and values that impact on practice. Braine (2009) considered this to be a prerequisite for the development of clinical skills.

2.3. Reflective Practice in Mental Health Nursing

Scanlam and Chernomas (1997) have indicated that research in relation to teaching or assessing reflection is limited, with a lack of literature specifically on how teachers develop reflective skills. Atkins and Williams (1995) and Haddock and Bassett (1997) suggested amongst nurse trainers a deficiency in training and knowledge in how to be reflective exists, which is reflected in their difficulty with providing adequate support to develop nurses' reflective practice. O'Conner, Hyde and Treacy, (2003) reported evidence that a number of nursing teachers had limited experience of utilizing reflection, and considered it as non-integral within the curriculum. This raises questions about who may be best placed to offer effective reflective practice group facilitation to inpatient staff teams where working conditions are challenging, staff face issues of complexity and are subject to unconscious internal and external processes.

In a study of nurses attending pre- and post-registration courses in the UK, Paget (2001) found 83% (n= 70) found reflective practice groups to be 'useful' or 'very useful'. Approximately half of the nurses reported increased insights and self-awareness, leading to changes in their practice. The role of the facilitator was seen as 'very important' by the majority of nurses, who preferred a group format for reflective practice compared to one-to-one reflection during clinical supervision.

However, some researchers have questioned the empirical evidence relating to the effectiveness of reflection on learning and professional development amongst nurses. Lowe and Kerr (1998) questioned the effectiveness of reflective practice, suggesting other teaching methods may be equally as effective. In addition, Nicholl and Higgins (2004), and Carroll et al (2002) raised doubts about the importance placed on reflective practice in light of the paucity of research evidence to validate its use.

The attainment of higher levels of reflective capabilities through experiential learning processes suggests the need for skilled facilitation to guide and support clinicians through the exploration of experiences encountered within their clinical practice. The following section will address the role of psychology within acute psychiatric settings. The potential for supporting staff through psychologically informed reflective practice using psychological formulations will be considered.

3. **The Role of Psychology in Acute Inpatient Settings**

The role of psychology in inpatient psychiatric settings is multi-faceted (Hanna, 2008). Alongside offering complex therapeutic interventions to patients in need of psychological support, psychologists are increasingly involved in providing training and support to multidisciplinary staff teams, assisting them in understanding and processing the complex issues that arise from working with patients who are experiencing psychological distress. Psychologists assess and formulate service users' difficulties and present a distinct and important perspective on distress to both the client and the multidisciplinary team (Kinderman, 2005).

Psychologists possess an array of specialist skills and expertise to provide a range of psychological interventions. Nicholson and Caraddice (2002) suggest psychologists work on three levels; direct therapeutic work; team consultancy, including formulations and recommendations for treatment; and on a more strategic level. McGowan and Hall (2009) highlights anecdotal evidence suggesting indirect working with teams have greater beneficial outcomes compared to exclusive clinical work, and that such interventions can influence the overall care and treatment an individual receives.

Psychologists are increasing involved in supporting staff teams in developing their psychological understanding, and play an important role in meeting the supervision needs of staff working with complex behaviour within challenging clinical settings (Hanna, 2008).Using their knowledge and expertise in formulation and group processes, they are well positioned to provide support to teams in terms of clinical supervision and facilitation of reflective practice groups.

3.1. Psychological Formulations

Kinderman (2005) suggests the use of psychological formulations by inpatient staff teams can assist them towards developing a more psychologically minded approach to providing care and treatment. Hanna (2008) has advocated the use of psychological formulations in acute inpatient settings to provide an alternative conceptualization of service users' problems and offer a more exploratory narrative compared to a medical model. He suggests that by understanding the factors that contribute to service users' problems and the mechanisms maintaining them, inpatient staff are able to change their perception of mental 'illness', leading to a more compassionate stance that embraces models of recovery. This can enhance outcomes for individual service users, increase teams' psychological thinking, and impact on an organisational level and staff patient power relations. Horowitz (1997) found that using psychological formulations reduced service users' emotional distress, enhanced motivation to change, and improved therapeutic alliance. In addition, Persons (1993) suggests the use of formulations help in facilitating the planning of interventions and maintaining client-therapist collaboration.

The following section will provide an overview of some of the theoretical underpinnings relating to the development of reflective capabilities.

4. Theories related to the Development of Reflective Capacity

In contrasts with conventional psychiatric practice which focuses on symptom classification and management of behaviour, Cameron et al., (2005) has suggested the use of the Object Relations Model (Klein, 1946) to enhance therapeutic nurse patient relationships. This allows psychiatric nurses to develop a greater awareness of internal and unconscious

mechanisms experienced by inpatients. Psychodynamic formulations can assist with the understanding of behaviour and unconscious defences (Lucas, 2003), and encourage consideration of the impact of early developmental factors, whilst highlighting transference and counter-transference information (Garelick & Lucas, 1996).

Psychodynamic theory proposes that infants have an innate method of coping with distressing and intolerable internal states by developing primitive defences such as splitting and projection (Klein, 1946). In the 'paranoid-schizoid' position the infant experiences intolerable conflicting emotional states, such as love and hate, creating ambiguity and a fear of annihilation. Consequently, this aspect of personality is 'split' off and 'projected' into the unsuspecting primary object; the mother or primary caregiver. The projections are identified by the infant as being part of the object, and behaviour is geared towards obtaining a validating response from the object.

Traumatic experiences or disruption to the primary caregiver relationship can result in increased use of projective defences. This obstructs psychological development and progression to what Klein (1946) labelled the depressive position, which enables the integration of different aspects of the self and conflicting internal states. It is thought that individuals experiencing episodes of psychosis are more likely to have their capacity for integration impaired (American Psychiatric Association, 1994). Because projective defences are considered universal, thereby existing to varying degrees within all individuals, professionals can potentially project their own unwanted aspects of self into others, including those who are under their care and support.

Working closely with people suffering from psychosis is likely to increase exposure to projective phenomena that could potentially activate psychological defences in individual staff members.

4.1. Mentalization-Based Psychodynamic Theory

The cognitive ability enabling the interpretation of another individual's behaviour is referred to as mentalization (Fonagy, Gergely, & Target, 2007). The capacity for mentalization is considered to be essential for healthy adult functioning and forms the basis for affect regulation, impulse control and empathy. Mentalization is considered to be primarily 'a preconscious imaginative mental activity' (Fonagy et al., 2007), which allows an individual to understand and think about their own mental states and those of others (thoughts, feelings). Mentalization involves three core functions; an instinctive understanding of behaviour which leads to the interpretation of behaviour as intentional; the depiction of others' minds and mental states allowing possible inferences relating to intent; and an ability to deduce, elucidate and rationalize an individual's actions on the basis of inferred mental states (Fonagy et al., 2007).

Mentalization capacity develops during infancy and can be closely associated with the quality of care that an infant receives from their primary care giver and the subsequent quality of the attachment (Fonagy et al., 2002). The need for a secure attachment is biologically predetermined and pre-adapted, thereby ensuring an infant attempts to achieve proximity to their attachment figure or caregiver (Bowlby, 1982). Mentalization-based psychodynamic theory suggests an infant develops mental representations which form the understanding of their own and other's minds. This process occurs by the caregivers' mirroring, or representing back to the

infant their own preverbal affective states (Fonagy et al., 2002). Abuse or mistreatment during developmental stages can impede the attachment process because the infant perceives a threat when thinking about the mind of the caregiver, which consequently reduces the child's reflective capacity.

Within secure attachments the mirroring process of the caregiver allows the child to develop affect regulation as the experience is linked with feelings of containment in relation to distress (Fonagy & Target, 2006). This enables the infant to develop a sense of agency and lead to psychologically meaningful interactions. The reflective, or mentalizing self develops from the interactions with another mind within an intersubjective framework. In this process, "the infant finds an image of himself in his mother's mind, as an individual with thoughts and feelings" (Fonagy, & Target, 1996b, p. 229).

It is argued, the ability to reflect, empathise and demonstrate a capacity for mentalization in relation to others, are the key underpinning personal qualities required in developing a positive therapeutic relationship (Steadman & Dallos, 2009). Empathy is defined as an ability to think and relate on an emotional level to the inner life of others (Kohut, 1984), whilst obtaining meaning and making sense their emotions (Thwaites & Bennett-Levy, 2007). The cognitive processes necessary for empathy appears to be the utilisation of instinctual capacities to understand individual's behaviour, together with a determined interpretive theorizing process.

This capacity for self reflection, allows the infant to construct representations of their own and other's actions, and is counter to the pre-reflective self, which is 'the immediate and

unmediated experiencer of life, incapable of taking an observing and knowing stance with respect to itself' (Fonagy, Steele, Steele, Moran, & Higgit, 1991). The goal of mentalization based psychotherapy is to reduce distress by the restoration of a healthier attachment relationship with clients (Fonagy, 2000). It could be argued therefore, that the potential for enhancing reflective capacity through increased mentalization is possible in more functioning and adaptive adults.

Within reflective practice groups, psychologically trained practitioners may provide acute psychiatric inpatient staff with a structure akin to a secure attachment relationship, which potentially has the capacity to develop an individual's mentalization capacity. If this is the case, then one could argue that this may lead to a enhanced ability to understand the minds of others, leading to increased empathy and the development of more therapeutic relationships with patients. This may generate improved outcomes for patients, as evidence suggests the primary component in facilitating change and positive outcomes in therapeutic interventions is the quality of the therapeutic relationship (Lambert & Ogles, 2004). In addition, psychologically trained practitioners providing facilitation to acute inpatient reflective practice groups can play an important role in containing the anxiety generated from uncertainly, thereby helping staff teams to reflect on internalized processes, and allowing staff to gain valuable insights.

Having explored the role of psychology in acute inpatient mental health services, and the relevant theories related to the development of reflective capacity, the following section will

consider the research evidence relating to the use of psychological formulations in reflective practice groups.

4.2. Evidence-Base for Psychological Formulations used in Reflective Practice Groups

The following review of the empirical literature considers the evidence examining the use of psychological formulations in reflective practice groups in psychiatric settings. The electronic databases PsycINFO (1806-April 2011), Ovid Medline (1948-April 2011), CINAHL (1960-February 2011), and the British Nursing Index and Archive (1985-April 2011) were searched to identify the relevant literature. The search terms encapsulated reflective practice terminology, including; reflection, reflective practice, reflective practice groups, clinical supervision, group supervision, staff support groups; combined with mental health nursing, psychiatric services; and psychology and facilitation. Further manual searches were conducted. The search strategy identified five studies specifically relating to inpatient mental health services; two from older adult services and three from adult services. Each study will be critically reviewed.

Wainwright and Bergin (2010) used qualitative methods to evaluate a pilot study on the use of psychological formulations for staff on an acute older people's inpatient mental health ward. The sample included two registered nurses, an occupational therapist, a health support worker and a staff grade doctor. Case formulation discussion groups were offered to staff that referred patients in their care. Data were collected at two points in the study, prior to the groups commencing, and when groups had finished. The groups were facilitated by a clinical psychologist and accredited cognitive behavioural therapist. The groups were open to all staff

and lasted for an hour. Using thematic analysis the study found that staff perceived the groups as useful, and were considered an important forum for discussing the psychological concerns they had regarding patients. The authors noted that psychological formulations influenced care planning and helped the staff team to gain greater insight and develop a shared understanding of patients' difficulties. In addition, the study reported staff were able to progress in instances where they faced challenging behaviour, and had previously been hindered. Staff also had more empathy and tolerance towards patients. They concluded formulations were useful in helping staff to consider the psychological factors and suggested this may have a positive impact on care.

A strength of the study was the collection of data at two points which allowed the authors to demonstrate the impact of psychological formulations on the participants in the study. The study was limited by the sample size of six participants, and the fact that data was only collected from one ward. The evidence was collected by the authors who noted a potential for participant bias based on the positive response to the groups from the staff team.

Craven-Staines, Dexter-Smith and Li (2010) undertook a three year evaluation of the integration of psychological formulations into older person's services across two localities. Twenty multidisciplinary staff including inpatient staff participated in the evaluation. Using semi-structured interviews, the authors reported on key themes including increased understanding of clients, and greater awareness of what they could and could not offer within their clinical work. Formulations helped create more individualised care plans which generated a holistic approach to care, which was considered to have a positive impact on the quality of care. In addition, staff believed the formulation meetings enhanced multidisciplinary team working,

whilst recognising the importance of individual professional roles. Obtaining the views of staff from two localities and the sample size was a strength of the study. However, no formal qualitative analysis of the data was undertaken; instead the authors identified key themes which were agreed through consensus.

In an evaluation of a reflective practice group facilitated by a psychologist on an acute inpatient ward, Shepherd and Rosebert, (2007) reported positive outcomes from staff attending the group. Nursing staff considered it was helpful to be able to discuss cases in the group, which helped with the management of their work with service-users. The use of a cognitive-behavioural framework to formulate cases by the facilitator was found to be helpful, and enabled a broader understanding of service users' presenting difficulties. The authors suggested that having a clinical psychologist to facilitate the group helped staff to make psychological theory-practice links, which enabled staff to become more aware of how theory related to a service-user's behaviour. Some staff reported experiencing the group as another task to be completed, and there were also reports from staff that presenting material in the group was anxiety provoking, which limited their participation.

The importance of gaining the support of the ward manager, who encouraged and motivated staff to attend, was highlighted. Staff felt there needed to be a greater number staff attending regularly and suggested that input from the wider multidisciplinary team would be of benefit. The study used quantitative and qualitative methods, but the response rate of eleven questionnaires was a limitation of the study.

Summers (2006) carried out a study of psychiatric staff's views of using psychological formulations in a rehabilitation setting. Semi-structured interviews were conducted amongst 25 participants using qualitative methods based on grounded theory. The study reported positive benefits from staff in terms of care planning, staff satisfaction and team working. This was achieved by a greater understanding of patients by adopting a more creative approach to care. According to Summers (2006) the content or validity of the formulation did not matter, instead she suggested gains occurred by improved understanding of patients, or by considering them as individuals instead of patients. The study did not establish what impact the formulations had on treatment outcomes, or to what extent the suggested benefits occur. The limitations of the study included the limited data collected due to the short duration of the interviews (20 minutes maximum) and the omission of recorded interviews which were written 'where possible verbatim'. In addition, the study highlighted further questions that needed to be addressed in terms of the extent to which the benefits occur, and questions relating to the accuracy of the psychological formulations.

Berry, Barrowclough, and Wearden (2008) undertook a pilot study with 30 inpatient staff using quantitative methods to examine the effects of using formulations on staff appraisals of service users' mental health problems and perceived control over symptoms. Psychological formulations were based on cognitive behavioural models, interpersonal theory, cognitive analytical theory and attachment theory. The use of psychological formulations were perceived by staff to improve the level of control by service users' in relation to their problems and symptom management. Staff also reported improved feelings towards patients.

A limitation of the study was the limited numbers of participants and the absence of data relating to how psychological formulations impacted on service users' treatment plans. The authors recommended that further research should be carried out into the impact on staff perceptions of mental illness, and on the impact of relationships between staff and service users.

5. Conclusion

The use of psychological formulations within reflective practice groups on acute psychiatric wards are a new and developing area (Summers, 2006). However, there is limited research on the effects on staff of providing a structured space to think psychologically and reflect upon their practice. Reflective practice is an intellectual and affective process, aimed at engaging individuals in the exploration of personal experience to foster greater understanding; and to enable practitioners to approach problems through a conscious process of structured thinking that results in the development of practice- based knowledge.

Developing the therapeutic culture within acute psychiatric wards requires the support of the organisation and a willingness and desire from staff to change existing working practices. Psychologists working in acute inpatient wards have demonstrated an ability to enhance the reflective capacity of staff leading to a more therapeutic ethos with potentially positive outcomes for both patients and staff. Psychologists are well placed to provide reflective practise group supervision to teams because of their broad knowledge and skills base, enabling the exploration of complex and challenging phenomena, within the confounds of a contained and supportive space.

5.1. Areas for Further Research

There remains limited research relating to the learning and development of reflective capabilities across professions (Moon, 1999), with a lack of conclusive empirical evidence to support its use in clinical settings (Shutz, 2007). Furthermore, little research exists on the processes or outcomes of experiential groups to facilitate reflective learning (Platzer, Snelling, & Blake, 1997), and a paucity of research into the impact of reflective practice within acute psychiatric settings, both on inpatients and ward staff. The limited evidence from staff attending reflective practice groups using psychological formulations is promising, with increased understanding of patients' difficulties, improved attitudes towards mental illness, and enhanced staff and patient relationships reported.

Further research is needed to provide an insight into the experiences of acute inpatient ward staff attending reflective practice groups facilitated by psychological staff. To explore the impact of using psychological theory, models and formulations on nursing staff's thinking and practice, and the effects on treatment interventions and outcomes. To date, no study has focused specifically on the experiences and psychological processes of ward staff attending a reflective practice group using psychological formulations within a grounded theory research framework.

Three broad research questions emerged from this review that warrant further investigation;

1. To what extent do reflective practice groups facilitated by a psychologically trained practitioner impact on acute psychiatric inpatient ward staff's psychological understanding and clinical work?

2. How do staff process and link psychological models and theories gained through attending reflective practice groups, to their clinical practice and theoretical orientation?
3. What are the significant factors that enable staff to process and operationalise psychological concepts and models?

The use of a qualitative methodology would appear to be an appropriate method of gaining a detailed understanding of acute psychiatric staff experiences of using psychological formulations. A qualitative method, for example grounded theory (Glaser & Strauss, 1967) enables the systematic analysis of a phenomenon, which can lead to the generation of a theory. Grounded theory offers the potential for developing a theoretical model, which could enhance understanding of how acute ward staff experience, process and operationalise psychological knowledge, thereby providing valuable information which could be utilised within acute psychiatric inpatient services in the NHS.

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INDEPENDENT RESEARCH PROJECT

Section B

Exploring psychological processes in reflective practice groups in acute inpatient wards:

A grounded theory study

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Abstract

The role of applied psychologists working in inpatient services is developing with a greater emphasis on providing support and consultation to staff teams. The research suggests that psychologically trained practitioners who facilitate reflective practice groups using psychological formulations can assist staff in developing a deeper understanding of patients' difficulties, with the potential for improved treatment outcomes. This study aimed to address some of the gaps in the research by exploring the experiences of acute psychiatric inpatient ward staff attending reflective practice groups facilitated by psychologically trained practitioners. Using semi-structured interviews, nine multidisciplinary staff from four acute wards participated in the study. Grounded theory methodology was applied to investigate how staff experienced, processed, and operationalised psychological knowledge in their clinical practice. The results suggested staff increased their psychological understanding through a process of guided reflection, development of theory-practice links, and validation. This enhanced a capacity for mentalization, which generated a more compassionate and empathic stance. The clinical, theoretical and research implications are presented.

Introduction

Acute Psychiatric Inpatient Wards

Psychiatric inpatient wards are considered by many service users to be non-therapeutic, restrictive and dangerous, culminating in an unpleasant and stigmatising experience (Muijen, 1999; Quirk & Lelliott, 2001; Rose 2001; Department of Health, 2002). There is often a lack of psychological provision offered to service users during admissions (Clark & Wilson, 2008), and limited interactions with staff (Higgins et al., 1999). Bray (1999) found that nurses were willing to engage in therapeutic work, but felt unsure about which interventions were most appropriate, especially when confronted with patients experiencing high levels of disturbance.

Reflective Practice

The development of reflective practice skills are considered important in developing effective clinical practice and expertise, role satisfaction (Chinn & Jacobs, 1987; Department of Health, 1999; Hargreaves, 1997; Johns, 1995; Landeen et al., 1995; Sainsbury Centre for Mental Health, 2000), and in generating greater awareness and understanding of complex practice issues (Crowe, 1998; Eckroth-Bucher, 2001; McAndrews & Samociuk, 2003; Minghella & Benson, 1995; Welsh & Lyons, 2001). Reflective practice can be defined as a process of self-examination involving retrospective analysis of practice in order to attain professional growth and development (Ruth-Sahd, 2003). Carr (1996) suggests reflection is an affective and active process facilitating exploration of experience aimed at increasing awareness and understanding, and an essential component in helping individuals learn and develop their knowledge and skills base (Bennett-Levy, 2003).

Schon (1983) identified two mechanisms of reflection; reflection-on-action, and reflection-in-action. Reflection-on-action occurs post-event, and allows the analysis of the event to enhance practice in the future. This can lead to a better understanding of practice, and a means by which learning is developed through experience. Reflection-in-action is the capacity to critically think about ones' own actions in the moment when encountering complexity and unfamiliarity.

Evidence Base for Reflective Practice Groups using Psychological Formulations

To date only five studies have been published investigating the use of psychological formulations by psychologically trained practitioners facilitating reflective practice groups (RPGs) in acute inpatient psychiatric settings. Shepherd and Rosebert (2007) reported the cognitive-behavioural formulations enabled a broader understanding of service users' presenting difficulties. The authors suggested that having a clinical psychologist to facilitate the group helped staff to make psychological theory-practice links, which enabled staff to become more aware of how theory related to a service-user's behaviour.

Summers (2006) reported benefits to care planning, staff satisfaction and team working through increased understanding, and convergence of staff with different views encouraged a more creative approach to care. The author argued the content or validity of the formulation was not important, instead she suggested gains occurred by improved understanding of patients, or by considering them as individuals instead of 'patients'.

Berry et al, (2008) found staff increased their understanding of patients' difficulties, which generated more positive feelings and optimism in relation to treatment outcome. The use of psychological formulations was perceived by staff to improve the level of control by service users' in relation to their problems and symptom management. The study did not address how psychological formulations impacted on service users' treatment plans, and further research was recommended into the impact on staff perceptions of mental illness, and on the impact of relationships between staff and service users.

Wainwright and Bergin (2010) noted that psychological formulations influenced care planning and helped the staff team to gain greater insight and develop a shared understanding of patients' difficulties. In addition, the study reported staff were able to progress in instances where they faced challenging behaviour, and had previously been hindered. Staff also had more empathy and tolerance towards patients. They concluded formulations were useful in helping staff to consider the psychological factors and suggested this may have a positive impact on care.

Craven-Staines, Dexter-Smith, and Li (2010) reported increased understanding of clients, and greater awareness of what they could and could offer within their clinical work. Formulations helped create more individualised care plans which generated a holistic approach to care, which was considered to have a positive impact on the quality of care. In addition, staff believed the formulation meetings enhanced multidisciplinary team working, whilst recognising the importance of individual professional roles.

Summary and Research Aims

Although the current evidence-base is limited, the five studies suggest the use of psychological formulations have a number of potential benefits to psychiatric inpatient staff teams. However, the nature and degree of the benefits needs further investigation, along with the circumstances under which the benefits occur. Furthermore, no studies to date have focused on the processes involved in developing psychological understanding amongst inpatient staff and the methods by which psychological knowledge is operationalised.

The study aimed to add to the literature by exploring the factors that lead acute psychiatric inpatient mental staff to develop psychological understanding and knowledge, and to identify the role of psychologically trained practitioners within this process. It was anticipated that through exploration, a theoretical model would emerge detailing the processes involved for staff in developing and operationalising their understanding of psychological theories and models, and the potential impact this had on their clinical practice. This study therefore provides an appropriate and timely addition to the existing research.

Research Questions

The study addressed the following research questions;

1. What is the impact on ward staff attending RPGs facilitated by a psychologically trained practitioner in relation to their psychological understanding and clinical work?

2. How do staff process and link psychological theories and concepts gained through attending RPGs to their clinical practice and individual theoretical orientation?

3. What are the main factors that enable staff to process and operationalise psychological concepts and models?

Method

Participants

Twenty multidisciplinary staff members from four adult acute inpatient mental health wards in one NHS mental health Trust who attended bi-weekly RPGs were invited to participate in the study.

Inclusion criteria for inpatient ward staff.

- Ward staff working within the local NHS Trust at the time of interviewing.
- Ward staff who had attended at least six RPGs for a period of six months or more.

The inclusion criteria ensured staff had been exposed to sufficient case discussions using psychological formulations in the groups. Ward staff that had attended less than six groups during the previous six months were excluded.

Sample.

Nine acute inpatient mental health staff who met the inclusion criteria agreed to participate in the study (eight women and one male) from one mental health Trust. The sample included five qualified nurses, three health care assistants, and an occupational therapist. Their experience of working on the wards ranged from six months to 11 years (Appendix 1). A purposive theoretical sample was utilised to identify the potential participants. In grounded theory this allows participants to be recruited who possess the information required to explore the phenomenon under study (Strauss & Corbin, 2008). Theoretical sampling of participants continued until the emerging theoretical categories were fully developed.

Reflective practice groups.

Four RPGs facilitated by two psychologically trained practitioners were used for the study. The facilitators were a counselling psychologist and a trained psychotherapist. The groups ran bi-weekly during lunchtime handover periods and lasted 45 minutes. The groups had been operational for 18 months. Staff were expected to attend the groups and with an average attendance of six to eight staff members for each group. Staff members were asked to prepare an individual case for discussion which was structured using integrative psychological formulations.

Design

A qualitative methodology using semi-structured interviews was utilised due to the limited research evidence and the exploratory nature of the study. Grounded theory (Glaser & Strauss, 1967) was deemed the most appropriate qualitative methodology because it provided a

framework for studying individual processes, interpersonal relations, and the reciprocal effects between individuals and larger social processes (Charmaz, 2006). In addition, grounded theory provided a structure to understand emerging theory and aid the development of a theoretical model in relation to psychological processes (Henwood & Pidgeon, 2003). This enabled the study of the meanings participants attributed to them, and how they may have changed and developed over time. Also various levels of meaning attributed to participants' actions, including their stated rationalization; unspoken assumptions; their objectives for engagement; how it impacted on others including patients; and the effect of participants' actions on a personal and interpersonal level could be understood (Charmaz, 2006).

Procedure

Recruitment.

The support of the facilitators of the RPGs and permission from the managers of the four acute wards was obtained. The facilitators acted as the point of contact and source of further information. The researcher met with the staff teams on the wards during handover meetings to explain the purpose of the study.

If staff members agreed to participate they were provided with an information sheet and consent form (Appendices 2 and 3). Information about the research was provided to clinical staff which covered their right to withdraw from the study, issues of confidentiality, and anonymity.

Interview procedure.

Each member of staff completed the consent form before they were interviewed face-to-face by the researcher. Semi-structured interviews with staff lasted between 30 to 60 minutes, followed by the opportunity to debrief at the end of the interview. The interviews were recorded using a digital tape recorder. Participants were encouraged to be open and talk freely about their experiences of attending the groups. The interview schedule was piloted on a member of staff which did not result in any significant amendments, and was therefore included in the analysis. Open-ended questions were used to elicit detailed experiences from the participants. Prompts were used for elaboration and clarification of verbal communication.

Interview schedule.

In-depth interviews were conducted with participants using an interview schedule (Appendix 4) to elicit data based on their experiences of attending the RPGs. Interviews began with questions relating to general information, including professional background, level of training etc. This was followed by questions on past and present experiences of reflective practice and how this may or not have impacted on their professional practice. Questions then focused specifically on their experience of attending the group facilitated by the psychologically trained practitioner. A final open-ended question was asked to enable participants to discuss any further comments they wished to make in relation to the content of the interview, or any other issues that had been raised.

Data Analysis

Interview transcripts were analysed using systematic procedures through various analytical stages (Charmaz, 2006; Strauss & Corbin, 2008).

1. Each interview transcript was open-coded. This involved initial line-by-line definition of the text in the transcripts, leading to the selection of the most significant or frequent codes.

2. Focused codes were generated from the initial codes and were more descriptive, which helped to synthesis and organised large segments of data and to allow a more conceptual level of analysis (Charmaz, 2006).

3. The constant comparison method was used to identify similarities and differences in the data (Willig, 2001).

4. Axial coding was used to explore links between categories and sub-categories, which lead to the development of main categories.

5. Memos provided a means of defining the analytic properties of the codes and categories, and to study their individual components. Emerging thoughts and ideas were noted which informs a data trail of category development (Strauss & Corbin, 2008). (Appendix 5).

Quality Assurance

Methodological Rigour

A number of quality assurance measures were adopted to ensure the integrity, reliability and validity of the research. The interview schedule was piloted on one participant who remarked on the relevance of the questions and therefore did not result in any major revisions.

The influence of the researcher in the development of data in terms of potential biases and assumptions was addressed by the use of supervision and a research diary (Lincoln & Guba, 1985) (Appendix 6). To ensure transparency and reflexivity throughout the research process an audit trail was conducted. An example of an initial coded transcript (Appendix 7) has been provided, along with tables identifying the development of focused codes through to theoretical categories (Appendix 8). This informs the reader how the model developed.

Additionally, respondent validation was undertaken. Two participants provided feedback on the initial codes used to analyse their transcribed interviews and on the conceptual categories which formed the theoretical model. Verification was obtained in both instances confirming the credibility of the initial data analysis and the development of conceptual categories and theoretical model. In addition, a segment of a transcript was looked at by a second researcher during the analysis of the data. This was aimed at reducing potential bias during the initial-coding. The second researcher confirmed initial-codes were closely related to participants' transcribed accounts. Supervision provided a further check on the credibility of interpretations

and was used to discuss the categories emerging from the data and memos were used to guide the development of categories (Charmaz, 2006).

.

Ethical Approval and Considerations

Ethical approval was obtained from the NHS National Research Ethics Committee (Appendix 9). Compliance with the BPS code of ethics and conduct (2009) was ensured throughout the study. The researcher was aware of the potential issues that may have arisen in relation to staff divulging sensitive information about themselves or others during the interview process. All data identifying information was therefore removed from the analysis.

Results

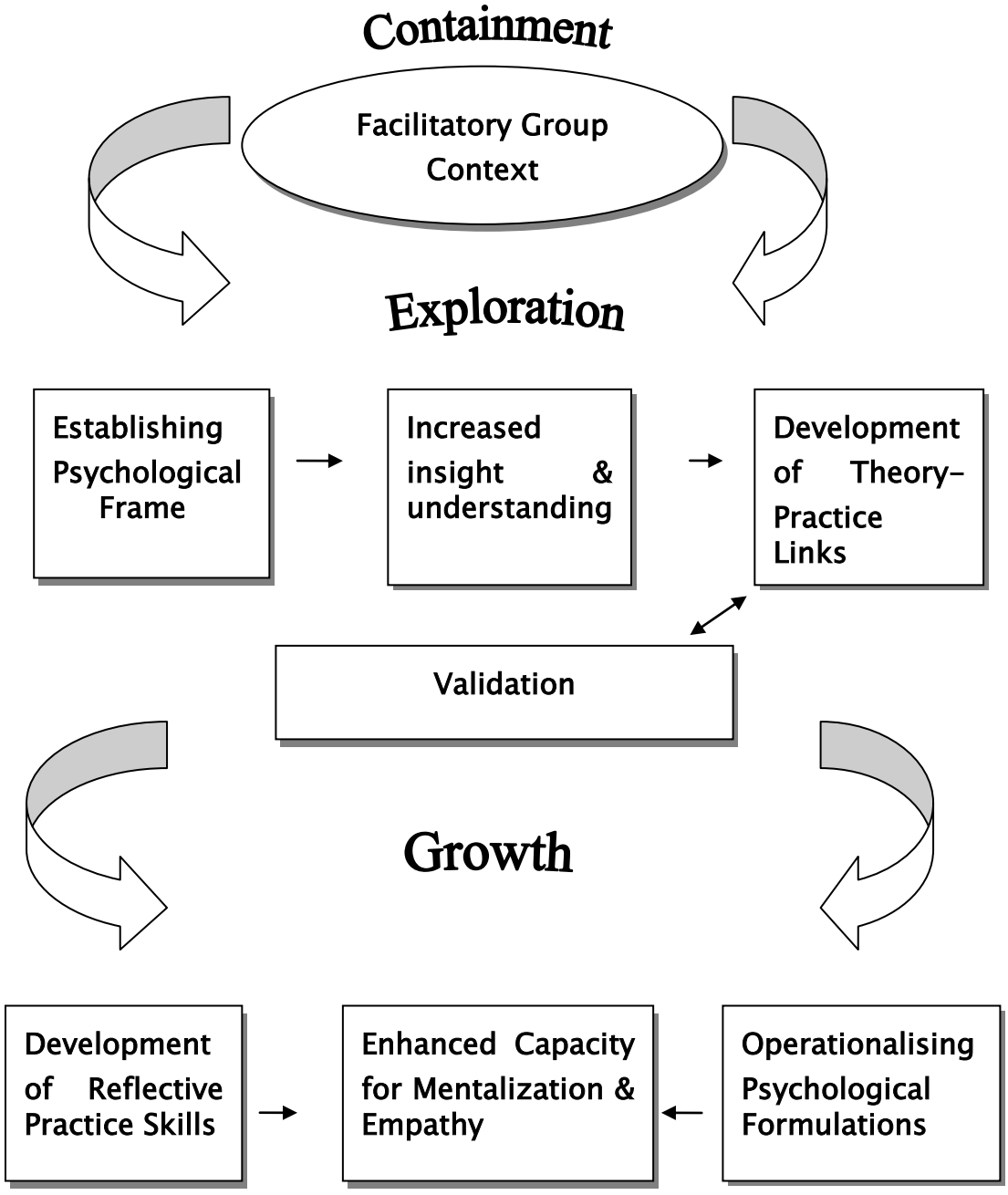
The initial coding stage generated 476 codes resulting in 37 theoretical codes (Appendices 8 and 10). These were refined into eight sub-categories which formed a theoretical model of the processes relating to the development of psychological understanding in RPGs. The three main categories; containment; exploration; and growth represent the temporal experiences of staff during the process of developing psychological understanding.

The Theoretcial Model of Psychological Understanding in Reflective Practice Groups

The theoretical model (see figure 1) was developed from the analysis of the data using grounded theory. The model describes the development of psychological understanding and is embodied within three stages; containment; exploration; and growth. Within the three stages, eight main categories were identified from the generation of initial-codes from transcribed data.

The model is presented using a flow diagram to demonstrate the hypothetical links between individual components. It represents an understanding of the processes involved in developing psychological understanding within the context of RPGs facilitated by psychologically trained practitioners. It is theorised that movement through this process enhances capacity for mentalization, resulting in greater understanding and empathy and more adaptive ways of working. Each main category will be described along with examples of quotes from participants.

Figure 1. Theoretical Model of Psychological Understanding in RPGs.



Main category: Containment

1. Facilitating Group Context

Facilitating group context identified the structural and conceptual factors which appeared to provide the foundation for staff engagement in the RPGs using a psychological framework.

Examples from the data reflect the importance staff placed on their experience of having a protected space which was containing and non-threatening. Creating an environment where group members felt safe and contained in the process of reflecting on their clinical practice was valued by staff and appeared to be a factor in developing exploration and understanding.

> "*The way it's structured, keeping the group together, I suppose it's group work isn't* it, they (psychologically trained professionals) have that background in group work, holding it, keeping the group together, understanding the group dynamics and how it *works."* (P5)

> *"I find it easier because he's there to facilitate, and I find he holds it together, stops it from getting out of hand."* (P6)

Several participants made comments relating to the value they placed on the reflective group as a space away from the busy ward environment to think and process their feelings and thoughts.

> "On a busy ward you would think you need to get on with your work during the day, but when you all get together, it gives you a chance to see what everyone else has been doing with that particular person, and it gives you options to perhaps work *differently."*(P1)

> *"To have that time away from running the ward, to* actually sit down and discuss clinical cases I think, just to be able to sit down in an environment with your colleagues with someone leading it and actually talk about anything [that comes up in the group], normally we would discuss a case that's pe*rhaps quite difficult that we're struggling with or we need extra ideas on, I think it's always useful to have time to talk about it."* (P9)

Staff appeared to value the group's potential to debrief and provide an opportunity to process their work on the wards. Some staff reported this helped to reduce their stress levels and increase staff morale.

> "*It's just good to have, and to know if you have got any sort of issues, there's a time and place to discuss it."*(P1)

"It's (the group) good for morale... time to debrief...it helps stress levels, if we've got incidents that are occurring on the ward *it's good to talk about it."* (P7)

One participant explained how the groups provided a more positive interpretation of the work.

"*If you're frustrated with a patient maybe sort of, even though it shouldn't, perhaps it* does come across, you know, so ...these groups do give more of a positive slant on *things."* (P1)

An important factor in exploring the meaning of patients' behaviour appeared to be the acceptance of beginning from a position of not knowing. This appeared to be encouraged by facilitators to allow staff to openly explore with each other, without fear of judgement from peers or sanction from the facilitator.

"It (t*he group) puts you at ease when you're in there and you feel that you can ask questions and sometimes you might feel that it's a strange question or whatever but if you ask, he says well no, and he explains what you are asking which is really good."* (P3)

*"*He makes you feel a bit more confident to ask questions and delve that little a bit *deeper."* (P2)

Main Category: Exploration

2. Establishing a Psychological Frame

Establishing a psychological frame was the main category that linked staff's engagement in the groups to developing an appreciation of the psychological factors underlying patients' behaviour. The use of psychological formulations provided a structure during case discussions. The majority of staff reported that having a psychologically trained practitioner as the facilitator enhanced their understanding of patients' behaviour, and provided a broader picture of the contextual factors. The specific skills and knowledge of the facilitator enabled greater clarification and explanation of the challenges and complexities faced by staff.

"We have to go into quite a lot of detail to describe the patient and draw a picture for him and for us, and by discussing one patient in depth, it makes people look at that patient anew and wonder where are we going with the *patient?"* (P3)

"I find it very useful having a case study in the groups because you're covering lots of different things, I suppose when he is doing them he looks at it from the psychology *side, the behaviour and that's really useful."* (P7)

The facilitators appeared to promote an exploratory stance, which seemed to be a significant factor in developing their psychological understanding and subsequent application of knowledge in their clinical work with patients.

"It's led very well...if we're struggling with a patient, sometimes we're not getting anywhere, you've got the facilitator leading it and he helps people with dragging things out. You can come up with a different approach in how you are going to deal with *this client that we're all struggling with and not getting anywhere."* (P9)

"Everyone's exasperated and pulling their hair out, and then we come up with a different approach, that *we've all agreed with it and the facilitator helps to* direct themes.*"* (P1)

The process of group discussion appeared to encourage several participants to consider contributory factors in relation to patients' behaviour, and helped staff to take an alternative perspective.

"I personally get a lot out of it because it helps me to recognise the situations of *patients that I wouldn't recognise if I hadn't been to these groups...he brings things up that we don't think of so it helps us a lot in that way."* (P2)

"Having a psychologist there allows you to stand back see it more from the *patients' perspective rather than your own."* (P5)

Another participant identified their capacity for creative thinking increased by attending the group.

"*Because of the way we use the group with him it's more sort of thinking outside the box."* (P6)

Several participants mentioned the group was particular helpful when used to discuss complex cases and in relation to patients who presented with challenging behaviour.

"We tend to pick out a patient that can be quite complex or we've worked with and *don't feel we're making progress*." (P6)

"*(The group is) really helpful especially if you've had a frustrating day, or you've* been finding a patient difficult to manage, it gets you thinking more...gives you new angles *to sort of work with."* (P1)

3. Development of Insight and Understanding

Development of insight and understanding resulted from participants exploring alternative psychological perspectives. It was a major theme that appeared throughout participants narratives.

> *"As a health care assistant we're not normally invited to case meetings, so it I feel you get a lot more insight (from the groups) into the patient."* (P4)

> "It (the groups) gives you more insight, more understanding of the individual, you look at things you may not even consider that might be important, so you have a chance *to understand the patient more."* (P5)

Awareness of different factors allowed the majority of participants to apply a more comprehensive view of the issues faced by patients, and to broaden their understanding leading to consideration of alternative explanations for behaviour.

> "*We get more insight into the patient that we're dealing with at the time that we* might find we have problems with and then he can enlighten us with different ideas that *we've not thought of...so it makes you think a bit more, for example, into their* past, what might have triggered something...trauma in life, or something that has *happened to them. You might think it's nothing, but to them it's really important, s*o it *brings that out, and we understand those patients a little bit more."* (P2)

"We'll talk about somebody, and he (the facilitator) might say, they're trying to do this, and that *helps us to think because he sees it from an outside view."* (P7)

"I think in-depth discussion about a patient opens your eyes to different factors you *can't see yourself... you look at a lot of social factors and the wider circle."* (P1)

"The group has quite a lot of impact really and think we have such a varied degree of patients with different problems and it highlights things that we might not think to *look into which helps us and helps the patient."* (P5)

4. Developing Theory-Practice Links

Developing theory-practice links outlines the process of assimilation of existing knowledge with newly acquired psychological understanding.

"Using psychological models has definitely been useful, bringing models in that we might have used during training, when you do the training you get taught to use the *models and theories, so it's definitely useful to bring it in."* (P1)

"The psychologists come from a different training background to us and think slightly differently to the way we kind of work, so it is helpful to have and it broadens my learning as *well."* (P6)

For one nurse the use of psychological theory to frame understanding of patients' behaviour appeared to generate interest in developing further understanding.

*"The way he talks it sort of stimulates your mind as well, and gets you to sort o*f want to *understand more and explore different (psychological) therapies."* (P5)

Less experienced staff benefitted from staff with more training and experience through the sharing of knowledge and skills.

*"Because of his input, those things trickle d*own ...that way of thinking, other staff take it *on board, and can then pass it on to the likes of me who have less experience"* (P3)

For some participants it appeared the group impacted on their level of self-awareness and helped them to recognise and understand unconscious psychological processes in relation to themselves and patients.

"*What's required is that you have insight into yourself and you understand why you're responding to people the way you do, or don't in some cases, and why you're* feeling *angry or frustrated with the patient."* (P3)

"*I'll think 'what was that (feeling) about', or I'm having a really strong transference*. All of that does filters into you, and the group changes your outlook and how you handle yourself... understanding possible counter transferences. You try and look inside *somebody else and think 'so that's going on', and then you approach* people in a *different way, your conversation becomes structured in a different way."* (P5)

5. Validation

Validation relates to examples of positive feedback received by participants from peers and the facilitators. This appeared to increased participants' motivation and confidence in applying existing and acquired knowledge and skills.

"*It's kind of nice if someone's* saying to you actually are doing the right thing, *because we always doubt the stuff that we do. It's nice to actually hear someone else say it because you don't get a lot of praise in this kind of job, especially from management."* (P4)

"*It's (the gro*up) positive because other team members give each other praise, and *because it is stressful it's nice to get a bit of recognition as well."* (P1)

A nurse recounted the process of engaging in the group over time, identifying its value when used to discuss complex issues raised by patients, leading to feelings of validation.

> "When it first started I personally felt that this is just a load of old rubbish to be honest, *I didn't think we were getting anything from it. But as they have gone on, you* do feel *it's valuable...especially if we're working with somebody personality* disordered. *You don't think you're making any progress, but he will reflect back* that the things you are doing may only be minute, but are actually positive for that patient, and you actually start to realise that you are getting somewhere even though *it doesn't it feel like it at the time. So it's quite validating."* (P8)

The groups also appeared to help participants' develop confidence in their own abilities which helped them to engage more with patients on different levels.

> *"I think it gives you more confidence to walk back out onto the ward...you're able to ask patients questions, and as I'm not trained, if there's something I don't* understand, *I'm able to say in the group, I don't understand that, can you explain it."* (P4)

> "I think the group gives me a lot more confidence, I probably had confidence before *but I didn't realise it until I've been doing these groups and it's reinforced my feelings."* (P2)

"It gives you that time to think about the things you are doing, so it makes you feel a bit more confident, if you make a suggestion that everybody says oh yeah, that's a good idea, or if you're not sure about something, getting everyone together saying I think *we should do this, I think it helps build your confidence, then it's more of a* team *effort especially if it's a difficult case."* (P9)

One of the nurses reported receiving positive feedback from patients which generated feelings that the team were doing the right things.

"*I think they're noticing more positive outcomes...I know I keep mentioning self-* harm, *but I have noticed a lot of that reducing."* (P1)

Main category: Growth

6. Development of Reflective Practice Skills

Development of reflective practice skills describes how participants incorporated reflection into clinical practice. The groups appeared to have a positive impact on ward staff's willingness to engage in individual and team reflective practice which filtered through into their everyday practice.

> *"I think it makes you more conscious of your practice, actually what you're doing, so* it makes you think about why you are doing this, and it helps to understand the *reasons behind what you would normally do."* (P9)

> "The staff team are always discussing with each other, how that person presented today, *what they did, what's working, so we're always reflecting with each other,* quite *openly. I think the group sort of stimulates you to do that."* (P1)

One participant explained the importance of reflecting on her work in the group context.

> "*I think it's quite difficult to do reflect alone, to stand alone with your own thoughts ...I think group supervision can play a big role in that."* (P3)

Being part of the group process appeared to be important in encouraging individuals to continue reflecting on their actions after the group had finished, and to consider and evaluate alternative and better ways of working.

> "*I think it's not until maybe later on when you have time, especially if it's a patient of* yours you discussed, then you can actually reflect on the 1-*1's that you've had with the patient and then think they've come up this (in the group), maybe I can try other* ways of interacting or working with this patient, asking questions and things, so it *certainly is beneficial."* (P4)

> "On my *practice it's had quite a huge benefit, because you can actually go away* from the group and *reflect on what's been said and try and work out where you as* a practitioner can meet their *patient's* needs, and also reflect on what the other members of staff have actually *said."* (P5)

> "*It makes you sort of actively think about the whole shift. As I'm driving home I'm* thinking, what I could have done different*ly, so it's making me actively reflect really...* and you come back the next day and all the stuff you may have been thinking about *you can then put into practice."* (P1)

For more experienced staff, the groups enabled the development of their reflective skills, which along with evidence of its efficacy, were inclined to use more frequently. This appeared to instil a belief amongst certain staff that reflective practice formed a crucial component in providing nursing care and support to patients on the ward.

> *"I think it's helping them, it definitely is helping me as well, just going back to the* ward with a different approach. You do actually reflect back and ask yourself should I have done that differently, would I do it differently next time. I think that's maturity *and the experience gained from reflective practice. Thinking to yourself that wasn't* the best approach, but it seemed like it at the time. You have to sort of reflect back daily really, am I making the right decisions here, should I have done that differently, *and finding better ways of doing it."* (P8)

Reflecting-on-action was a factor in fostering therapeutic relationships with patients, and avoiding defensive work practices, such as becoming task orientated and removing oneself from the emotional aspects of the work.

> *"It keeps you thinking about the cases because you should never become a task* orientated, it needs to be thought out, because a lot of our job is talking, its people skills. So I think even though you are a nurse and you have to have certain tasks *completed, it helps especially with therapeutic relationship."* (P5)

A nurse described how the group helped her to use reflective skills during interactions with patients. This appeared to represent a more advanced reflective capacity of reflecting-in-action. It allowed her to offer a more empathic response.

> *"It helps because it makes you stop and think* about the way you're interacting, what you're saying, and making it clear (to patients) that we are here to help, and we understand (them), so changing your role, and thinking about how you work and so on...kind of more *empathy."* (P8)

7. Operationalising Psychological Formulations

Operationalising psychological formulations described the application of psychological knowledge into clinical practice. One nurse explained how the group offered the possibility of taking different approaches with patients.

> *"It just gives you fresh ideas and different ways of approaching the patient...maybe you're going down one way, one sort of road and you feel that's it's not kind of working, so thinking back to the group we've had, maybe something that has been* suggested, then kind of going down that route to see if that one works...it opens up *different avenues for you."* (P1)

A health care assistant described feeling more confident in providing advice to patients.

> *"Because he gives you that bit more insight then you feel you're more capable of* seeing that patient in a different light and giving them more advice, whereas perhaps before *you might feel well I'm not sure if I should or not... you feel that bit better* about doing it, because you feel more confid*ent."* (P2)

The group appeared to help staff members in their 1-1 sessions with patients where the impact of negative projections from patients led to feelings of apathy in relation to their capacity to effect change.

"Thinking about 1-1 sessions with certain people and the way that you ask *questions...a lady that's very depressed, who's been here for a long time, and people* were feeling a bit lacklustre because nothing you said would help. So the facilitator would say how about asking this in this way and it makes you go and ask questions *differently, trying to think about different ways of talking to somebody."* (P3)

"I was able to go away and sort of work better on a one-to-one with that person on *the next shift."* (P8)

A newly qualified staff nurse explained how operationalising psychological understanding helped her to develop her clinical practice.

"I think it improved my practice, because it makes you think. You have one style of working as a professional, but it's always useful to hear other people's opinions, and it makes you think maybe I'll try this next time, or perhaps I'll do this, so I do think it improves your practice, and it helps you develop as a professional as well." (P7)

The process of sharing thoughts and ideas in the group with each other and the facilitator appeared to provide the team with a greater belief in their capacity to offer patients more help.

"*I feel that you can help patients more if you've got more insight into their* problems, and the facilitator gives you a different opinion to perhaps what your colleagues might see, so that brings another area that you might be able to help them

with, and I think it helps us with working with our colleagues, because you can act off one anot*her as well because you've all been in the group."* (P2)

A consistent and compatible team approach was considered as an important means of managing complex presenting situations and achieving desired outcomes for patients by a nurse.

"When you need to take more of a behavioural approach (with patients), if someone is causing a management problem on the ward, as in aggression to themselves or others, that's always useful to talk about with peers, to get others advice and to make sure *that everybody's* practices are compatible, so there's continuity with the care you're *delivering, that helps. Once we come away from the group we say, 'right, so* we've *decided x, y, and z, and then the primary nurse can put it into writing, and it's* something that e*veryone can follow."* (P8)

8. Enhanced Capacity for Mentalization and Empathy

An enhanced capacity for mentalization and empathy appeared to be linked to the integration of psychological understanding, along with increased reflective capability. Participants appeared to be more able to consider the patients' perspective, and in doing so cultivated a more empathic stance.

Increased psychological insight appeared to promote participants capacity to focus on the individual.

> "I think that it helps to remind some of the staff that these are human beings they're dealing with, and partly because of his input, the psychological input, you try to see *the whole even when it's quite difficult."* (P3)

> "I just think these meetings keep you within why y*ou're here and that's the patient,* the person themselves, so being a bit more patient-*centred."* (P1)

A health care assistant recounted her experience of discussing a patient in the group and how it facilitated greater understanding and an empathic response.

> *"I came out yesterday of the meeting and looked at them completely differently, I* suppose I could make allowances for his behaviour more, than when I thought it was *just through cannabis and drug misuse."* (P2)

The explication of contextual factors encouraged some staff to focus more on the person behind the behaviour.

> "*I just try to treat a patient as another human being and I feel it's my job to* separate in my head reality from non-reality...in psychosis and things like that. I try

and talk to that patient as another human being... to stay focused on the person... and *stick to the here and now. I suppose I'm a bit of a motherly figure."* (P2)

"*I think if the nurses are getting quite frustrated in a service users' behaviour, speaking about a person's background and some of the possible reasons they maybe acting like that...I think it sort of gives you a bit more empathy with that person."* (P1)

One participant explained how the team developed a more empathic understanding.

"*You get involved with patients a little bit you, you're sort of worried about them,* and *what's going to happen...and then I found that everyone in the group was* agreeing with me and having the same feelings. Sometimes you can feel alone with these *thoughts and feelings, so it's helpful to share your thoughts."* (P2)

Discussion

This study offers a theoretical model of how acute ward staff experience and develop psychological thinking in RPGs facilitated by psychologically trained facilitators.

The process of psychological understanding appears to develop within a facilitatory context that provides a safe and non-judgemental environment that allows staff to explore

important psychological factors underpinning patients' behaviour. By establishing a psychological frame to the groups by using formulations, staff appeared to begin to develop an appreciation and understanding of patients' behaviour, and an awareness of different contextual factors. Exploring psychological perspectives appeared to enable staff to gain greater insight and understanding. This seemed to aide staff in developing theory-practice links, which for some staff appeared to lead onto operationalising psychological understanding by incorporating theory into clinical practice. Validation through positive feedback appeared to have a motivating effect on staff and helped build confidence in applying their skills and knowledge.

For some participants, increased psychological understanding appeared to augment reflective practice skills, leading to a willingness to engage more in reflection as a result of the group, which filtered through into their everyday practice. Developing a capacity for increased mentalization and empathy appeared to suggest an advanced stage of reflective capability gained through attending the group, which seemed to cultivate a more empathic stance. Through a process of guided facilitation using psychological formulations, the results appear to suggest that ward staff developed an increased capacity for psychological understanding that had a direct impact on their clinical work and anecdotal evidence of improved patient outcomes.

This study found that in general participants experienced the groups as a safe, containing space that allowed them to explore their thoughts and feelings in relation to their work with patients and colleagues. The groups were experienced as non-threatening which generated an environment where they felt supported in developing a deeper understanding of the psychological aspects of their work with patients, whilst acknowledging the impact on

themselves and the team. The process was supported by the group facilitators who appeared to maintain two positions; the role of clinical supervisor, and a holding and containing position. This relates to the topography of clinical group supervision (Driver, 2008) where significance is placed on the interactional factors within the group and on group processes, alongside the needs of individuals, patients, the group and the organisation.

Important to the process of engagement in psychological exploration were staff's perception of the skills, knowledge and experience psychologically trained practitioners were able to demonstrate in the groups. Staff appeared willing to engage in a more exploratory role in the groups, often outside their comfort zone. This risked being exposed and judged as lacking in clinical skills and levels of competencies. They appeared to overcome their fears by internalising a facilitatory stance that encouraged risk taking and valued fallibility as necessary to the learning process.

By having psychologically trained practitioners as facilitators staff's exposure to psychological ideas and concepts was increased. This appeared to be the main factor in developing psychological understanding amongst practitioners. The study found that staff attending the group reported greater levels of psychological understanding and insight into patient's emotional states and behaviour. Furthermore emphasis was placed on the context of patient's behaviour and the impact of past experiences. This appeared to develop by understanding different psychological processes through active participation in the psychological formulation of patient's difficulties.

In addition, several examples of how staff had changed their approach to patients in clinical practice provided an indication of a willingness to use the knowledge and skills obtained in the groups. The use of integrative psychological formulations in case discussions appeared to provide a framework for staff to understand patients from different perspectives. From this a fuller picture of patients emerged, which allowed staff to consider alternative perspectives and a more comprehensive range of contributing factors pertaining to patients past, present and future experiences.

The study found evidence that the groups were experienced as a forum for learning from each other, especially staff with less experience or knowledge, who benefitted from listening and interacting with their colleagues. Discussions in the group were often referenced by staff in subsequent interactions, which reinforced psychological concepts and enabled understanding to be filtering through into clinical practice. This appears to relate to double-loop learning processes (Argris & Schon, 1974). The concepts of single and double-loop learning relate to action theories, consisting of espoused theories and theories-in- use. Espoused theories are theories individuals assert allegiance to, such as nursing theory, while theories-in-use are inferred from practice and action. An individual's actions may not necessarily comply with their espoused theories, but are always linked with theories-in-action (Argyris et al.,1984). Theories-in-use may not be overtly identified, remaining tacit until explicated through reflection, or when challenged. In the case of single-loop learning, challenges results in either a search for other explainable theories to achieve similar outcomes. In double-loop learning, the individual reflects on the structures which were active in their development and understanding.

The study appeared to establish a link between increased psychological understanding with an enhanced capacity for empathic responses, evidence by several participants demonstrating changes in their clinical approach and response to patients' needs. This included being more willing to interact with patients on an emotional level by spending more time on a 1-1 basis listening to their concerns and reflecting back their understanding.

Increased empathy appeared to be generated through the development of an increased capacity for mentalization. This appears to be linked with research into the developmental processes of mentalization, which theorises that infants develop a capacity to understand the mind's of others through interactions with another mind in an inter-subjective framework (Fonagy & Target, 1996; p229). Mentalization enables the child to connect with their own feelings as well as appreciating the minds of others, including feelings, beliefs, and desires. This process encourages connectedness with other people, and increased sensitivity. The basis of this process appears to relate to having a secure attachment figure that provides a safe and secure environment which enables attainment of reflective functioning. In the case of the group, it could be theorised that the facilitator adopts a position of secure attachment figure for individuals in the group, providing containment that enables and encourages mentalization processes in staff. The increased capacity to understand the minds of patients appears therefore to enhance empathic responses, forming the basis of more informed and meaningful therapeutic relationship with patients. The study also found evidence that the group appeared to provide staff with the knowledge and skills which increased their confidence in their own abilities to act in an emotionally containing manner.

This study found evidence that the group may have served to counter factors inhibiting mentalization capacities. In acute inpatient ward settings, staff are often subjected to projective phenomena from patients experiencing high levels of distress and states of confusion. This can lead staff to adopt defensive mechanisms aimed at reducing perceived external threats (Hinshelwood, 1999). Staff working with patients labelled as having a personality disorder, made references to their ability via the group to develop insight and understanding of projective phenomena, including identifying risks associated with team 'splitting'. Using a psychodynamic framework, it could be argued the paranoid-schizoid position postulated by (Klein, 1946) where individuals are confronted with intolerable levels of anxiety, invoking infantile defensive mechanisms aimed at survival, are contained, and movement towards a healthier 'depressive' position is reached.

Feelings of hopelessness and incompetence seemed to be overcome by sharing the emotional burden in the group, along with identifying and processing dynamic (processes). Forming a shared care plan allowed the teams to work more closely together and reduce the effects of exposure to 'primitive' defences such as splitting and projective identification.

Clinical Implications

Acute inpatient services form the front line of mental health services. Staff operate within an environment that places constant demands on their resources, dealing predominately with crisis and risk management, with few opportunities for therapeutic interventions (Allen & Jones, 2002).

This study found that staff value having a space to reflect on their work. The impact of RPGs appears to benefit staff on different levels, from improved team working to better staff patient relationships. The study also found anecdotal evidence of improved outcomes on the basis of improved staff and patient relationships.

Psychological input into RPGs on acute inpatient psychiatric wards can have a positive impact in helping staff to develop their understanding of the contextual factors underlying patients' behaviour and lead to a more patient-centred and holistic approach to care. In the light of these findings and from previous research, it would appear that inpatient services need to factor having more formalised structures for staff support which could include RPGs. Psychologically trained practitioners skilled in group work and facilitation can help to provide more effective and contained RPGs.

Staff appeared to benefit most from discussions of complex cases where the team felt current strategies were ineffective, and in the management of challenging behaviour including concerns raised around safety and incidents of self-harm. The use of psychological case formulations can provide staff with a framework to base their knowledge and understanding of patients; ensuring focus is maintained on factors important in providing appropriate care. RPGs were valued and appreciated by staff, who appeared to benefit from the containment provided, thereby increasing their ability to manage difficult emotional content.

Theoretical and Research Implications

The results suggest psychologically trained practitioners using psychological formulations may have enhanced ward staff's psychological understanding, with a number potential benefits to both patients and staff teams. Although the findings from this study cannot be generalised, the theoretical model offers a conceptual framework that can be adapted or modified by research conducted into other acute inpatient settings.

Further research will increase the profile RPGs in acute settings and benefit services by enabling better systems of staff support, and greater understanding of how best to utilise the skills of applied psychologists in facilitating or supervising other members of staff. Future research could include investigating the types of psychological formulations staff find most helpful/appropriate in their work, e.g., CBT, psychodynamic, systemic, or integrative would also benefit investigation to work towards optimising a model of psychologically facilitated RPGs. Outcome studies using standardised measures, for example scales measuring the therapeutic milieu, scales of staff satisfaction levels, comparing wards that operate RPGs with wards without groups could also add to understanding of the impact RPGs group have in inpatient settings. A further area of study would be to identify and quantify the impact on treatment outcomes.

Limitations

A limitation of the study included the sample size of nine. This was considered sufficient but may not have captured the full range of experiences within a staff team. Other factors included the demographics of the sample, which did not represent the wider diversity within the community. Regarding the recruitment of participants for the sample, there may have been

biased effects in relation to participants who agreed to participate having had more favourable experiences of the groups. This may have excluded the potential negative accounts that some staff who chose not to participate may have expressed.

Conclusion

This study has provided a constructive contribution to an under researched area with potentially positive theoretical and clinical implications. The study demonstrated that RPGs facilitated by psychologically trained practitioners could have benefits for individual clinicians and teams. There appears to be scope to increase staff's psychological understanding, generating greater effectiveness in their clinical work, and the potential for improved treatment outcomes.

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INDEPENDENT RESEARCH PROJECT

Section C

Critical appraisal

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Introduction

This paper presents a critical appraisal of the research process. It begins with a summary of the main research findings, followed by an evaluation of the procedures undertaken in terms of methodology, quality assurance and ethical issues. Personal reflections on the research process including the development of research competencies are presented. Research implications including clinical applicability and theoretical considerations will not be discussed in this section as this has been adequately covered in the research paper.

Summary of the Research Findings

The research aimed to explore acute inpatient mental health staff experiences of attending reflective practice groups (RPGs) facilitated by psychologically trained practitioners using psychological formulations. Using grounded theory methods, a theoretical model was developed which offered an explanation of the processes involved in developing and utilising psychological understanding. The model comprised of three stages; containment; exploration; and growth (pertaining to the main categories developed from the data). Within the three stages, eight theoretical categorised were devised describing the processes of developing psychological understanding.

For the majority of staff who attended the RPGs, having psychologically trained practitioners as facilitators appeared to increased their levels of psychological understanding and insight into patient's emotional states and behaviour. This was evidenced by increased emphasis placed on the contextual factors underpinning patient's behaviour. The process of guided facilitation using psychological formulations appeared to help staff to develop psychological

understanding that impacted on their clinical work with some evidence of improved patient outcomes. A brief description of the findings under the headings of the model will now be provided.

Containment

The first component of the theoretical model related to the Facilitating Context that provided staff with a contained, safe and non-judgemental environment which appeared to act as a prerequisite for exploration of psychological factors underpinning patients' behaviour. A number of staff members indicated the value of having a reflective space to discuss issues that had been raised on the wards, and reflected that the groups offered staff the opportunity to debrief and process their thoughts and feelings.

Exploration

Establishing a Psychological Frame to the groups by using integrative psychological formulations to structure case discussions of individual patients increased staff's exposure to psychological ideas, models and theories which appeared to stimulate a desire to delve deeper into underlying contextual factors pertaining to patients' behaviour. Development of Insight and Understanding indicated movement towards assimilation and processing of awareness of the contextual factors underpinning patients' behaviour. Developing Theory-Practice Links established an advanced theoretical position that linked previous theoretical and experiential knowledge with emerging psychological understanding. This provided the means for Operationalising Psychological Formulations and incorporating theory into practice. Validation

was generated through positive feedback from the facilitators, peers and in some cases patients. This increased belief in staff's professional capabilities to engage therapeutically, and was potentially a motivating factor in changing and adapting clinical practice.

Growth

Development of Reflective Practice Skills related to a readiness from staff to develop their reflective capabilities consequential to perceived benefits obtained from group attendance. The final component, Enhanced Capacity for Mentalization and Empathy suggested an advanced reflective capability which appeared to result in increased empathy towards patients by individuals and the team.

The model was informed by attachment theory (Bowlby, 1982), where containment equated to a secure base provided by the facilitating context. This offered staff an increased sense of security which enabled them to explore their own and their patients' internal mental states. Through a process of exploration, greater understanding was achieved, that provided opportunities for growth on an individual and professional level. This had the potential to enhance mentalization capacities, which increased levels of empathy and enabled staff to offer containment to patients. In summary, the theoretical model suggests staff developed psychological understanding through a process of containment which leads to exploration, and growth.

Increased psychological understanding was evidenced by staff's willingness to consider alternative reasons behind patients' behaviour and by addressing the wider contextual factors contributing to a patient's presentation. This appeared to help staff develop empathy towards patients, which was evidenced by changes in their clinical approach and response to patients' needs. Staff also reported being more willing to interact with patients on an emotional level and increase the time they spent listening to their concerns. Increased empathy appeared to be linked with the development of mentalization capacity. A capacity for mentalization enables a person to connect with their own feelings as well as appreciating the minds of others, including feelings, beliefs, and desires. This encourages connectedness with other people, and increases sensitivity (Fonagy & Target, 1996). This is vital, because the development of therapeutic relationships has been identified as a key indicator of positive outcomes (Lambert & Ogles, 2004)

Research Methodology

A critical appraisal of the methodological process will be offered along with the rationale for selecting grounded theory.

Sample

The study aimed to recruit 10 to 12 participants from six acute wards across two mental health Trusts. The initial recruitment stage involved meeting staff in two acute wards during handover meetings accompanied by a group facilitator. This strategy proved effective in recruiting six ward staff for the first phase of interviews, which were conducted at weekly intervals. A second phase of interviews involved a similar recruitment strategy across a further

two acute wards. This produced a further three participants. A third recruitment stage would have involved recruiting acute psychiatric inpatient staff from another mental health Trust. However, this did not materialise as the psychologically trained practitioner who facilitated two groups left the Trust and the RPGs ceased to operate on the wards.

However, the sample size of nine participants was deemed a sufficient number for the study as I had become aware during the latter stages of data collection (interview number seven) of themes being repeated. This led me to conclude I was approaching theoretical saturation, thereby reducing the need for further recruitment of participants. Riley (1996) has indicated that most grounded theory studies achieve theoretical saturation between 8-24 interviews depending on the area of research. However, it cannot be discounted that participants from another trust attending different groups may have enriched emerging theories or provided new perspectives to investigate.

Participants included four experienced nurses and one newly qualified nurse; an occupational therapist; and three health care assistants with between 1 year and 11 years experience of working in acute inpatient mental health wards. The participants were considered to be representative of the range of professionals which would be expected to form a staff team working in an acute inpatient mental health ward. However, the opportunity to recruit other multidisciplinary team members may have informed different perspectives and denied a further dimension to the study. In addition, participants who consented to participate in the study may have been biased in favour of the groups compared to staff that declined. Staff members who

chose not to participate in the study may have provided different experiences, including experiencing the groups as less beneficial.

Along with the caveats in relation to generalisability of grounded theory studies, no claim was made that the results offered a conclusive theoretical model that could be transferred to other settings. However, as (Charmaz, 2006) has indicated, grounded theorists should attempt to develop new theoretical interpretations of the data, as opposed to explicitly aim for conclusive interpretations.

As participants were only recruited from one Trust, this is a clear limitation of the study. In addition, most of the participants were female and therefore male participants may have provided a different viewpoint. In addition, all the participants were of white British ethnic origin, which narrows the potential variability that may have existed in relation to staff from different cultural backgrounds.

Semi-Structured Interviews

In the grounded theory literature, semi-structured interviews are a common means of gathering focused data (Charmaz, 2006). Using open-ended questions allows in-depth exploration of processes (Lofland & Lofland, 1984), which can lead to the emergence of unanticipated statements and narratives (Charmaz, 2006). The interview schedule was developed in collaboration with my external supervisor who had extensive experience of facilitating RPGs in acute psychiatric inpatient units. The schedule was piloted on a member of the ward staff, which did not result in the need for any revisions and was therefore included in the analysis.

By approaching questions in a sensitive and non-judgemental way, I was able to gain participants' trust and probe for deeper meanings in their responses. The semi-structured format allowed a more conversational style of questioning to develop. Charmaz (2006) has indicated the aim of in-depth interviewing is to explore participants' experiences, and not to interrogate them. During the course of the conducting the interviews, I became aware of developing my interviewing skills, which allowed me to become more comfortable in my role as a researcher. This created an environment where I was able to ask participants probing questions to expand on their responses, or to seek clarification. By delving beneath descriptions of their experiences, deeper underlying thoughts and beliefs were able to emerge.

Other methods of obtaining data from participants were considered, for example, using focus group as a form of data collection. However, this idea was rejected on the basis that detailed descriptions of psychological process would be harder to obtain in a group setting. In addition, some participants may have been put off by the prospect of discussing their thoughts about the group in the presence of their colleagues.

Rationale for using Grounded Theory

Based on the research questions and the fact that RPGs in inpatient settings using psychological formulations were under researched, grounded theory was deemed the most appropriate method. Grounded theory enabled the integration of complex psychological processes (Henwood & Pidgeon, 2003), and emphasises the generation of new theory which evolves during the process of research.

In addition, grounded theory offered the potential to develop a theoretical model from the data. This was important because no psychological models had been developed which explained the processes involved in developing and implementation of psychological understanding gained from attending RPGs facilitated by psychologically trained practitioners.

Grounded theory involves an iterative process of forward and reverse movement from coding to conceptualising data, and requires constant interplay between data collection and analysis (Charmaz, 2006). A theory is defined as an explanation of the phenomenon under study (Strauss & Corbin, 2008). Grounded theory is suited to research in areas where there is a lack of knowledge, or where different perspectives on existing knowledge are sought (Glaser & Strauss, 1967; Charmaz, 2006).

Different methodological procedures were considered, for example, interpretative phenomenological analysis (IPA) which shares similarities with grounded theory, and attempts to "explore the lived experiences of participants" (Reid, Flowers, & Larkin, 2005, p. 20). However, IPA focuses more on personal meanings as opposed to generating new theoretical understanding about psychological interactions and was therefore considered less appropriate for this study.

Epistemological Position

Mills, Bonner and Francis (2006) commented that within grounded theory a number of epistemological perspectives can be adopted. I adopted a social constructionist perspective which

proposes that the researcher forms part of the meaning emerging from the data, and this is predicated by the particular viewpoint of the respondent and the researcher. The researcher is assumed to be involved in constructing the data with participants, and the categories reflect what interactions occur between the observer and observed (Charmaz, 2006).

Quality Assurance

A number of quality assurance measures were adopted to ensure the integrity, reliability and validity of the research. The interview schedule was piloted on one participant who remarked on the relevance of the questions and therefore did not result in any major revisions.

To ensure transparency and reflexivity throughout the research process an audit trail was conducted. An example of initial codes from transcribed data was provided (Appendix 7) along with tables identifying the development of categories from open codes (Appendix 8). This informs the reader how the model developed. Written memos are considered to be an integral component of theoretical development (Charmaz, 2006) and an example was provided (Appendix 5).

The quality and validity of the study will be assessed against stringent guidelines for publication of qualitative research studies devised by Elliot, Fischer, and Rennie (1999). The guidelines are intended to increase quality control, promote methodological rigour and validity in qualitative research.

Owning one's Perspective

As with other qualitative methods, grounded theory places importance on clarifying the researcher's preconceptions, theoretical orientations and assumptions relating to the topic under study. This allows the reader to understand the position the researcher is taking in relation to the material, thus providing a contextual layer. Personal biases or assumptions in relation to the area of research were explored during supervision sessions and through entries in my research diary. One assumption I held prior to commencing the study was a belief that staff on acute inpatient wards would be resistant to reflecting on their practice. However, this proved counter-intuitive as the majority of the participants voiced a desire for more opportunities to attend the groups. The use of supervision and my research diary provided greater reflexivity and ensured the analysis of data was grounded in participant's descriptions.

Situating the Sample

Participants' demographic data was reported which enabled the sample to be contextualised in relation to individual's professional background, level of training and approximate number of groups attended over a specified timescale. A description of the groups and professional backgrounds of the facilitators was also provided. Demographic data allows the assessment in relation to the transferability of the findings to other reflective practice groups in acute inpatient settings.

Grounding in Examples

Participants' quotations covered a broad range of responses to the interviews questions and those presented in the results section represented an authentic account of individual experiences. Examples of participants' quotations were incorporated from transcribed data along with analytic interpretations. This illustrates the procedures followed by the researcher and allows readers to evaluate the "fit between the data and the authors' understanding of them" (Elliot et al.,1999), and to contemplate other potential interpretations of the data. In addition, the process of analysis from the development of initial codes through to focused codes and conceptual categories has been documented in tables (Appendix 8) thereby allowing the validity of interpretations to be assessed.

Providing Credibility Checks

Respondent validation is an important process in ensuring credibility (Henwood & Pidgeon, 2003). The use of credibility checks was carried out on the data to provide rigour and trustworthiness. At the end of each interview participants were asked whether they would be prepared to verify a sample of initial codes taken from transcribed data. Two participants provided feedback on the initial codes used to analyse their transcribed interviews and to offer feedback on the conceptual categories which formed the theoretical model. Verification was obtained in both instances confirming the credibility of the initial data analysis and the development of conceptual categories and theoretical model. This is considered important as the initial codes should remain close to an individual's account of their experiences. According to Riley (1996, p.36), "informants can be invited to assess whether the early analyses are an accurate reflection of their conversations". Interpretations of the data during the initial stages of

theory development presented to participants confirmed fidelity with their actual accounts. Following this another participant was approached In addition, supervision provided a further check on the credibility of interpretations. Lastly, a colleague experienced in grounded theory methods reviewed the analytic process.

Coherence

This principle relates to representing the data in a manner that is coherent and integrated whilst retaining nuances in the data. The findings from the study were presented in a theoretical model with clear links representing relationships between theoretical categories. Supervision was used to verify interpretive accounts of the data and to maintain coherence. The development of coherent theoretical categories was aided further by consultation with a colleague.

Accomplishing General verses Specific Research Tasks

The aims of the research were to explore acute inpatient staff's experiences of attending a RPG facilitated by a psychologically trained practitioner. The sample size of nine was considered sufficient (Riley, 1996) as it provided a representative sample of staff working in inpatient ward settings, and corresponded to the experiences from a range of clinicians from different professional backgrounds. The theoretical model may not be fully generalizable to other acute inpatient settings based on the specific sample used in the study. However, given that acute ward staff may be exposed to similar facilitatory experiences of RPGs in other acute inpatient settings, a number of the theoretical constructs may be applicable.

Ethical Issues

This section will outline the ethical issues relating to the research study. Ethical approval was obtained from the NHS research and ethics committee. Adherence to the British Psychological Society's (BPS) code of conduct and ethics (2009) was maintained throughout the research process.

Consent

Participants who agreed to take part in the research were provided with the information sheet which clearly stated a right to withdraw during any stage of the research. Informed consent was obtained from participants prior to commencing interviews in line with BPS guidelines. Participants were provided with researchers' contact details if they wished to withdraw from the research.

Confidentiality and Anonymity

To maintain participants' anonymity all identifying personal information was removed from the transcripts. At the end of each interview participants were asked whether they wanted any information removed before the interview was transcribed. Where a participant's professional background could potentially provide identifying information, participants were asked whether they wanted specific information relating to their professional identity removed from transcribed data and subsequent written analysis. In instances where participants referred directly to their clinical practice, all information relating to patients was removed by the researcher and no identifying information was included in the transcripts or analysis.

Participants were informed that data from the interview would be confidential accessible only to the researcher and kept on a computer that was password protected. Participants were made aware of the limits of confidentiality in relation to risk. In the case of witnessing or observing malpractice participants were informed of my duty to inform persons responsible for taking further action.

At the end of the each interview participants were offered a time to de-brief. During the research process no ethical issues arose and participants reported gaining insight and understanding into their experiences of attending RPGs.

Reflective Account and Development of Competencies

Selection of Topic Area

I was attracted to the idea of researching RPGs based on my experiences of working in teams where RPGs have been provided, experiencing firsthand the benefits of reflective practice on my clinical practice. In addition, I have worked in acute ward settings whilst being part of community mental health teams and have an interest in factors contributing toward the therapeutic milieu. Furthermore, I have experience of working in a therapeutic community where reflection is embedded in the culture of psychotherapeutic interventions. Lastly, my interest in groups and the potential to use the knowledge gained from undertaking the study in future clinical practice fortified my interest and instilled enthusiasm throughout the research process.

Development of the Initial Idea

During the initial literature searches, I was surprised by the limited amount of research into the area of reflective practice in acute ward settings, with only a handful of studies specifically addressing the use of psychological formulations. The original idea for the research study was to use quantitative methods using a pre-intervention and post-intervention design. The aim was to measure change amongst acute inpatient ward staff who attended an introductory 12-week training programme on cognitive behavioural therapy (CBT) formulations followed by weekly RPGs using CBT case formulations. The study planned to use a range of scales including the Ward Atmosphere Scale (Moos, 1974), levels of staff satisfaction, and impact on treatment outcomes. Whilst formulating the research idea and progressing through to the university's IRP review stage, the planned 12-week CBT training course for staff was abandoned by the trust. Following this my external supervisor accepted another post with a different trust.

A counselling psychologist who had been facilitating RPGs on acute wards for over a year agreed to act as my new supervisor. The changes necessitated a rethink in terms of my choice of methodology, and I decided that qualitative methods would provide a more suitable method of inquiry. Originally I was keen to explore the development of reflective practice and initially considered using a narrative approach. However, my new supervisor cautioned against relying on participant's past stories for narrative analysis as many staff members had been regularly attending the groups and may have struggled to recount their experiences and thoughts before attending the RPGs. Interpretive phenomenological analysis was also considered to illicit individual's accounts of their personal experiences of attending the groups. However, with the help of a member of the training course, I came to the conclusion that grounded theory offered

greater scope and flexibility to explore individual experiences of psychological thinking. I was also mindful that the choice of methodology emanates from the research questions, not the opposite was around, and grounded theory appeared to link with my research aims. In addition, the study focused on a relatively new topic area which presented an opportunity to formulate a theoretical model and contribute towards emerging theories.

By contemplating different methodological designs during the evolving nature of the study, I believe I developed my research competencies and gained knowledge in relation to three qualitative methods. I believe the conversion from quantitative to qualitative methods allowed greater insight into the experiences of staff and provided a working model of the components that influenced the development of psychological thinking within RPGs. Although using qualitative methods prevented generalizability, within participants' accounts there was greater depth and a richness of description which would have gone unobserved if I had used quantitative methods.

Research Design

On approaching grounded theory I initially found the different theoretical approaches and epistemological stances confusing. In addition, grounded theory had also developed different versions based on the original model by Glaser and Strauss (1967). Glaser (1992) believed meaning could be discovered in a research setting. However, Charmaz (2006) held the view that important issues may be hidden or elusive, and researchers form part of the data that is constructed. I adopted a social constructionist position as this fitted closely with the perspective of the study, in effect how people construct knowledge through individual and collective action.

The most difficult challenge during the design phase related to the development of the interview schedule. Charmaz (2006, p.33) indicates that questions need to relate to participants' experiences, without using leading questions, or "forcing responses". I became mindful that my preconceptions and biases may influence the emphasis I placed on individual questions. Supervision identified my initial tendency towards including some leading questions. This was noted and the revised final version of the interview schedule achieved a range of interview questions that encouraged "new reflections on existing experiences elicit rich data" (Charmaz, 2006).

Analysis

The experience of using grounded theory analysis proved to be both challenging and rewarding. The structure provided a marker to progress through the different stages of analysis. Initially, the wealth of coded data felt overwhelming. I amassed nearly 500 initial codes which needed to be arranged and categorised. Personally transcribing the transcripts ensured I remained close to participant's accounts. Ideas and initial theories developed from the initial coding and memos acted as a means to put free flowing ideas onto paper. I decided against using a computer package to arrange codes because I wanted to remain close to the data.

On completing the transcribed interviews and initial coding, I set about developing focused-codes. This process involved constant comparative analysis of the data. I questioned whether I was reaching a deep level of analysis and interpretation of the data. Receiving

constructive feedback on draft sections of the research study from supervisors helped to maintain a focus and develop my ideas further.

I began to form initial ideas for a theoretical model and the process refinement began. I became fully consumed in the analytical process, which was both anxiety provoking and stimulating as strands of the research converged. The analysis and write-up seemed to engage higher cognitive processes, thinking analytically whilst holding and moulding vast amounts of information and ideas.

Through conducting this research, I believe my research skills in relation to grounded theory have improved considerably. I have learnt the importance of applying rigorous standards in conducting qualitative research, and have developed a greater appreciation of methodological sound qualitative studies.

Reflections on Researcher Preconceptions and Bias

Given my experiences working in inpatient psychiatric settings therapeutic communities, I needed to be aware of any preconceptions or biases. During supervision I acknowledged my views advocating for increased psychological presence within psychiatric services as a counter balance to the medical model ethos. Potentially, this may have led me to focus more on the positives of psychological input at the expense of providing a more balanced perspective. I continually checked any preconceptions and biases by using my research diary and in communication with my supervisors.

Reflections on Findings

In relation to the findings of the study, I felt the data that emerged proved very promising and suggested that staff valued psychological input into their practice. The use of psychological formulations helped staff to structure their understanding of patients and appeared to foster a more person-centred approach. The theoretical model suggested staff may be able to develop their psychological understanding through a process of containment, which creates a sense of security to allow exploration of their own and patients' experiences. In the absence of a containing facilitatory structure, the process of reflection and exploration may have been hindered.

Since undertaking the research, I have learnt that some ward staff highly value opportunities to reflect on and develop their practice by having a dedicated protected space. I expected staff to show resistance to external psychological input and privilege practical work over reflecting. However, this was not the case and the staff that participated in the study appeared to value the opportunities psychological understanding offered in terms of greater insight and awareness. There was a willingness from staff to explore psychological meanings behind patients' behaviour, which often resulted in them adopting different approaches to suit patients' needs. This leads me to take an optimistic view on what can be achieved in a difficult and stressful environment, where management of risk and containment is seen as essential component of the work, and often takes precedence over the thinking and processing of experiences.

Psychologist are increasingly involved in supporting teams and the fact that staff found the groups beneficial adds weight to the importance of having a psychological presence in acute psychiatric inpatient settings. Hearing positive reports from staff about the benefits of psychological input in terms of the RPGs and in a wider sense, suggests psychologists have an important role in aiding development of acute psychiatric inpatient services. Psychologists appear to be a rare commodity in acute psychiatric inpatient services, therefore RPGs offer a means to increase psychological presence to the benefit of both patients and staff teams.

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Appendix 1: Ward Staff Demographics

Participant	Profession	Gender	Number of years of acute ward experience	Approx. number of groups attended
P1	Psychiatric nurse	Female	2	8
P2	Health care assistant	Female	3	10
P3	Health care assistant	Female	11	15
P4	Health care assistant	Female	1	6
P5	Psychiatric nurse	Female	2	8
P6	Occupational therapist	Female	6	10
P7	Psychiatric nurse	Female	1	6
P8	Psychiatric nurse	Female	8	12
P9	Psychiatric nurse	Male	9	15

Appendix 2: Invitation to participate in the research study

Participant/version number.....: Date..../...../.....

Invitation to participate in a research study

Exploring psychological process in reflective practice groups: A grounded theory study

Dear participant,

I am a third year clinical psychology doctorate trainee at Salomons, Canterbury Christ Church University, in Kent. The course requires trainees to complete research into a subject area that relates to clinical psychology. My interest is in the role of psychology within inpatient psychiatric settings. I would therefore be very grateful if you were willing to participate in this study.

The main aim of this study is to explore the psychological processes in reflective practice groups, and to evaluate their impact within inpatient psychiatric settings. The study hopes to generate information about how ward staff experience attending reflective practice groups, and what effects it may have on professional practice.

This study will be supervised by Dr *****, clinical psychologist and clinical tutor at Salomons, and Dr *****, consultant psychologist for ********** Trust. The study has been submitted for approval by NRES Ethics Committee.

Participation in the study will involve meeting with me to discuss your experiences of attending the reflective practice groups. The meeting will take approximately 45- 60 minutes. All information will be treated as strictly confidential, and each individual's identity will be protected.

Information about the study can be found in the enclosed participant information sheet.

If you feel you would like to participate in this study then please complete the participant consent form attached. If you require further information please contact me on **********.

Thank you very much and I look forward to hearing from you.

Yours sincerely,

Antony Collins
Trainee Clinical Psychologist
Salomons Clinical Psychology Training Course

Appendix 3: Participant Information Sheet

Participant/version number.....: Date..../...../.....

Introduction
You are invited to take part in a research study. This research is being carried out in part fulfilment of a Doctoral Degree in Clinical Psychology at Salomons Canterbury Christ Church University, Kent, by Antony Collins. Please take time to read the following information. If you would like to discuss this further or need more information, please contact me on **********.

What is the title of the study?
Exploring psychological process (and understanding) in relation to reflective practice groups: A grounded theory study

What is the purpose of the study?
This study aims to investigate acute ward staff's experience of attending the reflective practice group. It is hoped that the study will provide information on the impact on staff and patients of reflective practice groups. You are being asked if you would like to take part because your ward has a reflective practice group that is run by a psychologist. The study involves collecting data in the form of semi-structured interviews from people attending the reflective practice group.

Am I obliged to take part?
There is no obligation to take part and it is entirely your decision. If you decide to participate in this study you are free to withdraw at any time and without giving any reason. If you agree to take part I will contact you by telephone to arrange a convenient time and date to meet to discuss your experiences of attending the reflective practice group. The interview will focus on your experiences of the reflective practice group and how attending the group has influenced your professional practice in relation to your work on the ward. The interview will last approximately 45-60 minutes. When you have completed the interview you will have an opportunity to ask any questions you may have.

Issues of confidentiality
Any information collected in this study will be kept confidential and all data will be kept in secure storage for 10 years. All identifiable material will be disguised from the information collected. If during the interview you made known information that suggested you or someone else might be at risk of serious harm, then I would be obliged to pass this information on to an appropriate person. The study will be submitted for publication and consent will be sought to use anonymous quotes in published reports.

Further information
For any further information please contact me on the above telephone number. If I am unable to answer your call, please leave a message stating who you are and that you are calling about the research project. Please leave a contact number and I will get back to you as soon as possible.

Thank you for taking time to read the information sheet.

Appendix 4: **Consent form**

Participant/version number.....: Date..../...../.....

Title of project: Exploring psychological process in reflective practice groups

Name of researcher: Antony Collins

Please tick:

☐ I understand that my participation in this research study is voluntary and I am able to withdraw from the study at any time without providing a reason.

☐ I agree that obtained from questionnaire data may be used in this study and in subsequent publications. I understand that all information collected will be anonymous and I will not be identifiable from them.

☐ I agree to participate in the above study

Name: .....

Date: .....

Signature: .....

Appendix 5: Interview schedule

Participant/Version number.....1: Date..../..../.....

Interview schedule (prompts in italics)

Exploring psychological process in reflective practice groups: A grounded theory study

Section 1: General information

Q1. Could you tell me a bit about yourself?
What is your professional background, level of training, education etc?
How long have you worked on the ward?
What have been your experiences of working on the ward? Are they different from other places where you have worked?

Section 2: Experience of reflective practice

Q2. Could you tell me about any past experiences of reflective practice?
How did you experience this?
What impact did this have at the time?
Did it influenced/changed your practice in any way?

Q3. Could you tell me about your experience of attending the reflective practice group on the ward?
What led you to attend the group?
How often do you attend?
What are are the main reasons you attend the group?
What differences does attending the group make?
What would be different if you did not attend the group?
What aspects do you most useful? Why?
What do you find most difficult about attending the group? Why?
If you have experience of attending RPGs, how and in which ways is this one different?
How do you feel after attending the group?

Q4. What has been the impact on you personally of attending the reflective practice group?
How has the group impacted on your practice?
Can you describe how you practice has changed? What are the positives and negative of this?
Has attending the group in any way influenced how you experience your professional role?
Has attending the group influenced your attitude towards professional development and learning in any way?

Q5. The reflective practice group is facilitated by a psychologist, what are your thoughts and feelings about how the group is run and the facilitating style of the psychologist?
What has been most noticeable about how the group is facilitated?

If you have previous experience of reflective practice groups, how is this one different?
What has been your overall experience of having a psychologist to facilitate the group?
What have been the main benefits or negatives of having a psychologist running the group?
Has having a psychologist running the group influenced your understanding of patients' difficulties in any way?

Q6. What has been your experience of discussing patients in the group?
What have been the most/ least helpful aspects of case discussions?
How do you feel about using psychological ideas to understand patients' difficulties?
Has this changed since attending the group?
How do psychological ideas link with your professional identity and theoretical knowledge and understanding?
To what extent do you use the knowledge (psychological or otherwise) gained in the group with your work with patients?
What impact has this had on your work with patients?
What do you think has been the impact on patients?

Section 3: Impact on the organisation

Q7. What is the impact of the reflective practice group on the ward?
How has the group been experienced by the team?
What impact has it had, for example, on staff relationships with each other, including managers and medical staff?
What has been the impact of the group on clinical meetings, including ward rounds and care-planning meetings?
What has been the affect on staff/patient relationships and treatment outcomes?
How do you think this may have been experienced by patients? What are your thoughts and feelings about this?

Section 4: Debrief.

Q8. Are there any further comments you would like to make, or areas you wish to discuss about the content of our interview, or any other issues that may have been raised for you?

Respondent validation

To ensure I have fully understood the comments you have made, would you be prepared to spend a few minutes discussing the contents of this interview once the results have been analysed?

Thank you very much for your time and thoughts.

Appendix 6: Initial Grounded Theory Codes

1. Acknowledging individuals in the team have different perspectives
2. Thinking that different perspectives are dependent on the individual patient
3. Thinking that people with PD raise elevated thoughts
4. Communicating difficult experience of managing to 'nurse' people with PD
5. Discussing management concerns of patients
6. Trying different perspectives
7. Acknowledging positives of the group
8. Acknowledging the impact on thinking of a person like the facilitator
9. Stepping back to look at the person rather than the behaviour
10. Understanding the behaviour by looking at the person more holistically
11. Reflecting helpful if you've had a frustrating day
12. Reflecting helps manage difficult patients
13. Reflecting gets you thinking more
14. Reflecting gibe you new angles to work with
15. Making space to think allows potential to wok better in the future
16. Linking RP with training
17. Seeing it as a forum for discussing the talking points of a busy ward
18. Seeing value in time away from the ward
19. Getting together as a group allows opportunity to know what others are doing
20. Giving options to work differently
21. Learning from the experience of others
22. Thinking generates more positive thoughts towards the patient
23. Acknowledging stress and burn out
24. Understanding importance of reflecting when encountering fear
25. Sharing experiences whenever you can
26. Protecting time to think together
27. Talking and listening
28. Developing skills from hearing other's views
29. Reflecting/ attending the group not difficult to do
30. Developing various skills based on different ideas
31. Putting ideas into practice
32. Feeling positive about the group experience
33. Getting praise from others
34. Getting recognition in a stressful situation
35. Getting support from group members
36. Reflecting impacts on the whole shift (work)
37. Reflecting has continuous impact after the group has finished
38. Encouraging active reflection
39. Returning to work the next day with new ideas to put into practice
40. Benefitting from the experience
41. Reflecting build cohesion in the team
42. Acknowledging professional training is reflective practice based
43. Thinking about alternative therapies
44. Attending stimulates the mind

45. Wanting to learn and take up different therapies
46. Thinking about doing more training in the future
47. Acknowledging intuitive style of the facilitator
48. Putting a positive on a negative
49. Changing how you feel
50. Turing it around
51. Feeling fresh when you leave the group
52. Getting everyone talking
53. Everybody has something to say
54. Making you talk
55. Wanting more opportunities to participate in RPGs
56. Experiencing the group as positive
57. Wanting patients to have more input from psychology
58. Thinking the group generates understanding
59. Identifying no negatives
60. Proving possibility to think differently
61. Giving a new angle
62. Linking to professional practice
63. Psychology influencing understanding
64. Remembering root causes of behaviour
65. Factoring in other potential influences
66. Not forgetting past experiences
67. Reflecting on what influences behaviour
68. Thinking about positive impact of acknowledging service user's past experiences
69. Picking a person apart and putting them back together again
70. Influencing ways of working
71. Reflecting counters negative thinking
72. Stimulates thinking
73. Thinking after sessions
74. Thinking about what I should have done
75. Considering alternative approaches
76. Changing the way of thinking
77. Linking psychological ideas in practice
78. Thinking and working more holistically
79. Self-harming behaviour can get in the way of thinking about the person
80. Linking models with psychological theory
81. Pairing with psychology
82. Staff discussing with staff
83. Thinking about what (treatments) are working
84. Reflecting openly with staff
85. Group stimulating open reflection
86. Being more reflective with patients
87. Thinking that patients getting more positive outcomes
88. Noticing reducing self-harming behaviour
89. Patients talking more about positive changes

90. Witnessing changes in behaviour
91. Encouraging patients to reflect on their own feelings
92. Patients reporting positive feedback
93. Thinking more about the person
94. Going away and thinking more
95. Team valuing the meetings
96. Team cooperating with each other
97. Thinking clinical meetings are possibly more thorough
98. Reflecting more openly in clinical meetings
99. Using the meeting as a resource to mange frustration
100. Speaking about the person increases understanding
101. Giving reasons for behaviour
102. Giving more empathy with the person
103. Benefitting patients
104. Patients needing to know we care
105. Frustration interferes with relationships
106. Negative feelings can filter through
107. Group helping positive thinking
108. Finding groups very interesting
109. Getting insight into the patient
110. Understanding context of the patient
111. Proving more insight
112. Giving more confidence
113. Asking more questions
114. Gaining confidence to ask questions
115. Allowing to ask questions if don’t understand
116. Finding it helpful to be able to ask questions
117. Getting more confidence in what I'm talking about
118. Asking questions without feeling inhibited
119. Asking questions even if unsure there is an answer
120. Not feeling stupid about asking questions
121. Not finding the group difficult
122. Looking forward to the group
123. Thinking it is a learning experience
124. Getting insights from attending the group
125. Making a difference to the way I care
126. Getting more background information
127. Impact of the past
128. Valuing information
129. Not presuming
130. Making less assumptions than before
131. Gaining insights about patients
132. Allowing information to come out
133. Gaining meaning why you're here
134. Being here for the patients
135. The facilitator bring it back to thinking about the person

136. Influencing attitudes towards CPD
137. Feeling part of the team
138. Listening and talking, identifying needs of patients
139. Getting involved with patients
140. Identifying initial resistance from staff
141. Less resistance as the group develops
142. Acknowledging value of external facilitator; another voice
143. Benefitting staff and patients
144. Thinking it is better to have a person running the group
145. Taken seriously because psychologist facilitator is respected
146. Experiencing the facilitator as approachable
147. Linking patients to psychology input
148. Opening eyes up by having in-depth discussions
149. Seeing different factors not able to see yourself
150. Generating empathy
151. Understanding needs
152. Questioning why
153. Understanding impact of social factors
154. Acknowledging difficulties of patients experiences and impact of environment, social circumstances
155. Opening a wider circle of contributory factors
156. Understanding benefit of discussing 'revolving door' patients
157. Understanding contributory factors
158. Generating lots of questions for the team to ponder
159. Being surprised by own level of knowledge
160. Feeling able to discuss patients
161. Getting really involved
162. Menatailizing; being worried about patients issues they face
163. Witnessing team empathy
164. Sharing the same feelings in the team
165. Not feeling alone with your thoughts
166. People having the same thoughts
167. Confirming positives
168. Treating the person as a human being
169. Separating reality from non-reality
170. Seeing the person beyond the psychosis
171. Staying with the patients emotions
172. Developing listening skills
173. Getting involved
174. Awareness of transference and projections
175. Holding patients in mind
176. Giving more confidence
177. Reinforcing feelings and beliefs
178. Looking at the patients in a completely different light
179. Making more allowances for their behaviour
180. Seeing beyond pre-conceptions

181. Talking and reflecting more as a team
182. Getting tips on how to work with patients
183. The facilitator suggests we think and discuss it
184. Taking in past experiences
185. Helping with my job
186. Looking at things in different ways
187. Looking at them in ways we might not
188. Bringing out things you might not have thought about
189. Being a 2-way process, learning from each other
190. Helping to find solutions to problems
191. Being enlightened with different ideas
192. Making me think more
193. Considering other past events in a person's life
194. Placing more emphasis on what might be important to the patient
195. Bringing out other factors
196. Having more knowledge and understanding
197. Thinking outside the box
198. Giving opportunities to think differently
199. Providing alternative views to consider
200. Acting on the knowledge
201. Delving further
202. Seeing beyond the immediate
203. Looking deeper into what they are saying
204. Feeling better after getting more understanding
205. Feeling more confident
206. Being a deeper thinker
207. Knowing how far to go
208. Feeling more capable
209. Seeing patients in a different light
210. Giving out more advice
211. Feeling surer
212. Helping me understand more
213. Recognising different factors
214. Bringing out the unknown
215. Conversing more and asking more questions
216. Getting closer to the patient by asking different types of questions
217. Developing skills to ask the patients questions
218. Helping patients overcome difficulties
219. Picking up on patients' difficulties
220. Being more receptive to patients' needs
221. Holding the patients' anxiety
222. Reassuring patients
223. Getting to know the patients more
224. Less fear of saying the wrong things
225. Breaking down boundaries between staff and patients
226. Feeling more confident asking questions

227. Feeling more able to go and talk
228. Building a fuller picture of the patient
229. Getting the whole story
230. Putting knowledge into practice
231. Feeling valued in the group
232. Being put at ease
233. Getting over inhibitions to ask questions
234. Validating experience
235. Re-packaging your thinking
236. Explaining what you are thinking is helpful
237. Giving equal value to everyone's input
238. Allowing difference of opinion
239. Opening up dialogue to consider what is in the best interests of the patient
240. Impacting beyond the group
241. Knock on effect
242. Feeding from one another
243. Coming up with different ideas
244. Considering many different perspectives
245. Allowing and valuing different opinions
246. Seeing things in a different way
247. Moving to solutions more quickly
248. Benefitting from psychological input
249. Linking patients to psychology
250. Getting feedback from patients that psychological interventions are working
251. Understanding more clearly
252. Understanding the reasons behind the behaviour
253. Valuing insight the group provides
254. Looking at things not considered before
255. Knowing how you can help
256. Understanding more since attending the group
257. Thinking psychologically helps the patient
258. Feeling I can help more
259. Keeping different opinions in mid
260. Gaining belief
261. Having more knowledge and insight into problems to call upon
262. Psychology offering alternative perspectives
263. Bringing another resource to help
264. Generating ideas off each other
265. Group provides opportunity to use each other's ideas
266. Carrying ideas into practice
267. Impacting on the work
268. Highlighting things not thought about
269. Benefits to staff interaction
270. Reinforcing to each other what has been said in the group
271. Reminding each other of group discussions
272. Positive response from the team

273. Overcoming resistance
274. Improving staff relations
275. Allowing more communication with each other
276. Benefitting staff patient relationships
277. Getting positive feedback from patients
278. Attending to patients needs
279. Knowing how to talk with patients
280. Being more able to calm down situations
281. Knowing what helps
282. Seeing the bigger picture
283. Thinking you need s/v to reflect
284. Thinking RP difficult to do alone
285. Clinical s/v playing a big role
286. Having insight into self
287. Understanding responses to behaviour
288. Knowing why experiencing negative emotions
289. Stopping in my tracks
290. Identifying transference and counter-transference
291. Filtering into personal outlook
292. Looking inside others
293. Approaching patients in a different way
294. Communication structured differently
295. Believing less experienced staff more open to knowledge acquisition
296. Knowing when to intervene
297. Realising medication not the only treatment
298. Engaging more with patients
299. Being more mindful of staff and patients needs
300. Increasing psychological profile on the ward
301. Generating more questions about the patient
302. Getting the right information
303. Doing things differently
304. Taking a longer-term approach to care
305. Getting to know what is important
306. Linking well-being with psychology
307. Uncovering the person behind the behaviour
308. Thinking about the person as a person
309. Taking into consideration the personality
310. Reminding staff that we're dealing with a individual person
311. Using resources and knowledge from RP to remind staff of the human behind the illnesses
312. Allowing staff to share and communicate feelings of frustration and anger
313. Putting behaviour into context
314. Seeing the whole because of RP
315. Maintaining understanding during challenging behaviour
316. Maintaining ability to mentalize when faced with paranoid and suspicious patients

317. Generating empathic feelings towards patients
318. Filtering effects of RPGs
319. Placing value on the work of the team
320. Putting the jigsaw together
321. Slowly finding the pieces
322. Understanding the processes patients are going through
323. Becoming aware of group dynamics
324. Good for when feeling not making progress
325. Initially feeling the group was not useful
326. Getting more from the group as time goes by
327. Useful when discussing PD patients
328. Helping when feeling stuck with patients
329. Thinking about what you are experiencing
330. Reflecting back and receiving validation from the facilitator about the work with the patient
331. Becoming aware of the positive impact staff can make on patients
332. Realising change is happening
333. Bouncing ideas off each other
334. Using the resources of the team
335. Coming together and sharing ideas
336. Getting ideas on how to progress
337. Using, tapping the minds of others
338. Feeling stuck without the group
339. Revisiting clinical practices
340. Making sure you are progressing
341. Getting reassurance
342. Hearing that you are doing the right thing
343. Dealing with uncertainty
344. Holding and containing
345. Constructive questioning of practices
346. Getting positive feedback
347. Continuing to reflect after the group
348. Thinking outside the norm
349. Widening outlook
350. Having more ideas
351. Witnessing progress
352. Allowing expression of thoughts
353. Creating a safe environment
354. Generating exploration of thoughts and ideas
355. Working as a team
356. Supervising ourselves outside the group
357. Getting an external (outside) view
358. Acknowledging the value of the group to staff and patients
359. Using the group to talk about PD
360. Providing theoretical rationale to nursing practice
361. Finding reassurance in doing the right thing

362. Generating understanding and points of reference
363. Generating theory-practice links
364. Becoming more positive about the group over time
365. Initially being out of comfort zone
366. Becoming part of everyday practice
367. Impacting on a conscious and unconscious level
368. Transferring learning to the work place
369. Broadening learning
370. Being open to new ideas
371. The group as a reference point
372. Knowing you have the group as a support if required
373. Seeing positive impact on patients
374. Building trust amongst colleagues
375. Experiencing positive impact on the team
376. Preventing from being stuck
377. Feeling that you have done something helpful
378. Being re-invigorated
379. Being flexible and willing to use different approaches
380. Increasing patient-centred care
381. Coming up against resistance and using strategies to overcome resistance
382. Having a fresh and creative approach to care
383. Seeing more ways forward
384. Thinking more as a team
385. Going away discussing
386. Having impact beyond the boundaries of the group
387. Giving a chance to find out what is working
388. Finding ways of working better
389. Understanding patients issues
390. Opportunity to voice opinions
391. Taking on board what has been said in the group
392. Going away and reflecting
393. Reflecting on team, professional and personal issues
394. Reflecting on how we could do better
395. Working from the same song sheet
396. Building rapport with staff
397. Gaining understanding, stopping to think
398. Finding out what's working and what's not
399. Bringing the work into a frame
400. Feeling held by the group
401. Bring psychology into the group
402. Facilitating talk to generate open thoughts
403. Planting the seeds of thoughts influencing and directing the flow and path of thinking and ideas
404. Giving structure and instruction
405. Coming with a different angle
406. Turning towards the productive

407. Straddling the professional divide
408. Reflecting on other's voices in the group
409. Meeting the needs in the moment
410. Thinking in the here and now
411. Experiencing and learning from group dynamics
412. Thinking about your personal impact on the team and patients
413. Using the relationship to gain insight
414. Reflecting on all we do
415. Circularity of questioning practices
416. Seeking a better understanding of psychological aspects
417. Linking and combining theories
418. Integrative practice
419. Fitting models and theories to the patient
420. Facilitator understanding group processes and dynamic
421. Keeping the group together
422. Getting insights into other's roles and theoretical frames of reference
423. Seeing more from the patient's perspective
424. Standing back and seeing more
425. Reinforcing learnt theories
426. Bringing knowledge to the surface
427. Supplementing the medical model
428. Understanding how the patient is feeling on the ward
429. Thinking about the impact of their illness
430. Being in tune with the patient
431. Being aware of the changing environment of the ward (patient dynamics)
432. Seeing change, adaptation and growth
433. Being sensitive to changes in the patient
434. Using psychological models to inform practice
435. Patients being open to receiving input
436. Getting patients to understand where they are coming from
437. Not feeling the need to take control
438. Generating more choices for patients
439. Being focused on recovery
440. Seeing patients responding positively and retaining the experience of different approaches from staff
441. Understanding rationale of each other's treatment approach
442. Valuing each other's input with patients
443. Impacting on future planning of care and treatment
444. Patients changing negative attitudes towards staff
445. Building and rebuilding relationships with patients through greater understanding
446. Empathizing not sympathizing
447. Experiencing more open communication between staff and patients
448. Putting self in patients shoes
449. Focusing and seeing the positives over the negatives
450. Realigning the patient experience

451. Having more tools to move forwards
452. Expanding purpose of inpatient care
453. Managing distress and pain
454. Feeling empowered to change the way things are done
455. Building and nurturing the TR
456. Reducing hopelessness and increasing hope
457. Seeing value in small but significant interactions
458. Helping you think about what you are feeling
459. Learning from what you are feeling
460. Picking up messages from what you are feeling
461. Making you aware of assumptions
462. Engaging in different thought processes
463. Dealing with uncertain events
464. Learning and development being a 2-way process
465. Exploring and developing hypothesis
466. Building staff morale
467. Letting off steam
468. Generating a protective space
469. Allowing thoughts to emerge
470. Freeing up space to think
471. Getting clarification
472. Encouraging thinking
473. Asking questions of oneself
474. Acknowledging the internal states of patients
475. Dismantling unhelpful barriers to care
476. Acknowledging the psychologist is able to be sensitive to the group's needs

Appendix 7: Focused Codes

A: **THE IMPACT OF PSYCHOLOGICAL FACILITATION**

Understanding the function of external facilitation

8. Acknowledging individuals in the team have different perspectives??
142. Acknowledging the value of external facilitator; another voice
144. Thinking it is better to have a person running the group
263. Bringing another (external) resource to help
357. Getting an external (outside) view
402. Facilitating talk to generate open thoughts??
404. Giving structure and instruction

Raising psychological profile

57. Wanting patients to have more input from psychology
147. Linking patients to psychology input (2)
248. Thinking patients benefit from psychological input
249. Linking patients to psychology *
300. Increasing psychological profile on the ward
401. Bring psychology into the group

Providing alternative perspectives

101. Facilitator giving reasons for behaviour
147. Groups opening eyes up by having in-depth discussions
149. Seeing different factors not able to see yourself
187. Looking at patients in different ways
188. Bringing out things you might not have thought about (2)
214. Bringing out the unknown
252. Understanding the reasons behind the behaviour
254. Looking at things not considered before *
262. Psychologist offering alternative perspectives
401. Planting the seeds of thoughts

Changing thought processes/ influencing and directing the flow and path of thinking and ideas

13. Having a psychologist facilitate promotes reflection and gets you thinking more
44. Attending the group stimulates the mind
60. Providing the possibility to think differently
72. Stimulates thinking
76. Changing ways of thinking
152. Questioning more
192. Making staff think more
198. Providing opportunities to think differently

199. Providing alternative views to consider
206. Becoming a deeper thinker
235. Re-packaging your thinking
462. Engaging in different thought processes
472. Encouraging thinking

The group experienced as accessible
52. Getting everyone talking
53. Believing everybody has something using to say
54. Making you talk
112. Gaining confidence from the group
117. Getting more confidence in what I'm talking about
160. Feeling able to discuss patients
234. Validating experience of the group
237. Giving equal value to everyone's input
238. Allowing difference of opinion
245. Allowing and valuing different opinions
390. Opportunity to voice opinions

Encouraging exploration
113. Asking more questions
114. Gaining confidence to ask questions
115. Allowing to ask questions if don't understand
116. Finding it helpful to be able to ask questions
118. Asking questions without feeling inhibited
120. Not feeling stupid about asking questions
158. Generating lots of questions for the team to ponder
226. Feeling more confident asking questions
233. Getting over inhibitions to ask questions
301. Generating more questions about the patient

Developing understanding and insight
58. Thinking the group generates understanding
100. Thinking psychologically about the person increases understanding
109. Getting insight into the patient
111. Providing more insight
124. Getting insights from attending the group
131. Gaining insights about patients
196. Developing more knowledge and understanding
212. Helping me to understand more
246. Seeing things in a different way
251. Understanding more clearly
256. Understanding more since attending the group

397. Gaining understanding, stopping to think
424. Standing back and seeing more
465. Exploring and developing different hypotheses

Group process and containment
*[1]420. Facilitator understanding group processes and dynamic
47. Acknowledging intuitive style of the facilitator
299. Being more mindful of staff and patients needs
372. Knowing you have the group as a support if required
421. Holding and keeping the group together
476. Acknowledging the psychologist is able to be sensitive to the group's needs

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Staff valuing protected time
17. Seeing it as a forum for discussing the talking points of a busy ward
18. Seeing value in time away from the ward
26. Protecting time to think together
283. Thinking supervision helps reflection
284. Thinking reflection is difficult to do alone
285. Acknowledging role of clinical supervision
334. Using the resources of the team to reflect
335. Coming together and sharing ideas
468. Generating a protective space

Groups experienced as valuable to staff
7. Acknowledging positives of the group
32. Feeling positive about the group experience
56. Experiencing the group as positive
59. Identifying no negatives
121. Not finding the group difficult
122. Looking forward to the group
167. Confirming positives
253. Valuing insight the group provides
325. Initially feeling the group was not useful
326. Getting more from the group as time goes by
338. Feeling stuck without the group
364. Becoming more positive about the group over time
365. Initially being out of comfort zone

Encouraging positive thoughts
22. Thinking psychologically generates more positive thoughts towards the patient

[1] * denotes in-vivo focused code

47. Facilitator putting a positive on a negative
71. Reflecting counters negative thinking
107. Group helping positive thinking
129. Putting a positive on a negative
135. The facilitator bringing it back to thinking about the person??
180. Seeing beyond pre-conceptions
257. Thinking psychologically helps the patient
427. Supplementing the medical model
461. Making you aware of assumptions

B: PROCESSES OF PSYCHOLOGICAL UNDERSTANDING

The processes of deconstruction and reconstruction
66. Thinking about patients' past experiences
69. Picking a person apart and putting them back together again
184. Taking in past experiences
201. Delving further
202. Seeing beyond the immediate
228. Building a fuller picture of the patient
244. Considering many different perspectives
282. Seeing the bigger picture
320. Putting the jigsaw together
321. Slowly finding the pieces

Generating creative thinking
61. Giving a new angle
186. Looking at things in different ways
191. Being enlightened with different ideas
197. Thinking outside the box
243. Coming up with different ideas
333. Bouncing ideas off each other
348. Thinking outside the norm
349. Widening outlook
350. Having more ideas
354. Generating exploration of thoughts and ideas
370. being open to new ideas
405. Coming with a different angle

Focusing on solutions to problems
13. Reflecting provides new angles to work with
75. Considering alternative approaches??
190. Helping to find solutions to problems
247. Moving to solutions more quickly
261. Having more knowledge and insight into problems to call upon??

336. Getting ideas on how to progress
379. Being flexible and willing to use different approaches
382. Having a fresh and creative approach to care
383. Seeing more ways forward
398. Finding out what's working and what's not
470. Freeing up space to think

***393. Reflecting on team, professional and personal issues**
388. Finding out what's working and what's not
394. Reflecting on how we could do better
408. Reflecting on other's voices in the group
414. Reflecting on all we do
472. Asking questions of oneself

Expressing and processing feelings
23. Acknowledging stress and burn out
34. Getting recognition in a stressful situation
51. Feeling fresh when you leave the group
99. Using the meeting as a resource to mange frustration
105. Frustration interferes with relationships
106. Negative feelings can filter through
204. Feeling better after getting more understanding and acknowledgement
312. Allowing staff to share and communicate feelings of frustration and anger
467. Group allows staff to let off steam

Receiving positive feedback
33. Getting praise from other team members
319. Placing value on the work of the team
330. Reflecting back and receiving validation from the facilitator about the work with the patient
340. Getting feedback that you are progressing
341. Getting reassurance
342. Hearing that you are doing the right thing
346. Getting positive feedback
361. Finding reassurance in doing the right thing

Group containment
11. Reflecting helpful if you've had a frustrating day
343. Dealing with uncertainty
344. Holding and containing
353. Creating a safe environment
400. Feeling held by the group

463. Dealing with uncertain events

Developing awareness of psychological processes
63. Psychology influencing understanding
174. Awareness of transference and projections
236. Explaining what you are thinking is helpful
288. Knowing why experiencing negative emotions
290. Identifying transference and counter-transference
329. Thinking about what you are experiencing
458. Helping you think about what you are feeling
459. Learning from what you are feeling
460. Picking up messages from what you are feeling

Learning from the group experience
*411. Experiencing and learning from group dynamics
286. Having insight into self
323. Experiencing and learning from group dynamics
367. Impacting on a conscious and unconscious level
431. Being aware of the changing environment of the ward (patient dynamics)

Developing increased capacity for empathy
*150. Generating empathy
102. Giving more empathy with the person
163. Witnessing team empathy
168. Treating the person as a human being
317. Generating empathic feelings towards patients
322. Understanding the processes patients are going through
423. Seeing more from the patient's perspective
446. Benefitting patients
448. Putting self in patients shoes

Developing appreciation of the context of behaviour
10. Understanding the behaviour by looking at the person more holistically
64. Remembering root causes of behaviour
65. Factoring in other potential influences
67. Reflecting on what influences behaviour
68. Thinking about positive impact of acknowledging service user's past experiences
110. Understanding context of the patient
127. Impact of the past
153. Understanding impact of social factors
155. Opening a wider circle of contributory factors
157. Understanding contributory factors

178. Looking at the patients in a completely different light
179. Making more allowances for their behaviour
193. Considering other past events in a person's life
195. Bringing out other factors
209. Seeing patients in a different light
213. Recognising different factors
307. Uncovering the person behind the behaviour
308. Thinking about the person as a person
309. Taking into consideration the personality
310. Reminding staff that we're dealing with a individual person
313. Putting behaviour into context

Working with complexity and challenging behaviour
4. Communicating difficult experience of managing to 'nurse' people with 'PD'
5. Discussing management concerns of patients
12. Reflecting helps management of complex cases
156. Understanding benefit of discussing 'revolving door' patients
324. Good for when feeling not making progress
327. Useful when discussing 'PD' patients
359. Using the group to talk about 'PD'
376. Preventing from being stuck

Development of theory-practice links
62. Linking to professional practice
80. Linking models with psychological theory
360. Providing theoretical rationale to nursing practice
363. Generating theory-practice links
417. Linking and combining theories
419. Fitting models and theories to the patient
425. Reinforcing learnt theories

C: <u>INTERGRATION AND ASSIMULATION OF PSYCHOLOGICAL KNOWLEDGE</u>

Developing patient-centred and holistic care
93. Thinking more about the person
133. Gaining meaning why you're here
134. Being here for the patients
171. Staying with the patients emotions
220. Being more receptive to patients' needs
221. Holding the patients' anxiety
222. Reassuring patients
258. Feeling I can help more

331. Becoming aware of the positive impact staff can make on patients
380. Increasing patient-centred care
428. Understanding how the patient is feeling on the ward
430. Being in tune with the patient
433. Being sensitive to changes in the patient
453. Managing distress and pain

***475. Dismantling unhelpful barriers to care**
225. Breaking down boundaries between staff and patients
412. Thinking about your personal impact on the team and patients
413. Thinking about your personal impact on the team and patients
437. Not feeling the need to take control
452. Expanding purpose of inpatient care

***86. Being more reflective with patients**
91. Encouraging patients to reflect on their own feelings
292. Looking inside others
436. Getting patients to understand where they are coming from
474. Getting patients to understand where they are coming from

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316. Maintaining ability to mentalize when faced with paranoid and suspicious patients
24. Understanding importance of reflecting when encountering fear
79. Self-harming behaviour can get in the way of thinking about the person
169. Separating reality from non-reality
170. Seeing the person beyond the psychosis
287. Understanding responses to behaviour
351. Maintaining understanding during challenging behaviour
381. Coming up against resistance and using strategies to overcome resistance

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***447. Experiencing more open communication between staff and patients**
27. Experiencing more open communication between staff and patients
126. Getting more background information
138. Listening and talking, identifying needs of patients
172. Developing listening skills
203. Looking deeper into what patients are saying
207. Knowing how far to go
215. Conversing more and asking more questions
216. Getting closer to the patient by asking different types of questions
217. Developing skills to ask the patients questions
223. Getting to know the patients more
276. Benefitting staff patient relationships
279. Knowing how to talk with patients

280. Being more able to calm down situations
281. Knowing what helps
296. Knowing when to intervene
298. Engaging more with patients
302. Getting the right information

***278. Attending to patients needs**
151. Understanding needs more
194. Placing more emphasis on what might be important to the patient
218. Helping patients overcome difficulties
219. Picking up on patients' difficulties
255. Knowing how you can help
409. Meeting patients needs in the moment
439. Being focused on recovery
456. Reducing hopelessness and increasing hope

Building therapeutic relationships
125. Making a difference to the way I care
139. Getting involved with patients
175. Holding patients in mind
293. Approaching patients in a different way
429. Thinking about the impact of their illness
445. Building and rebuilding relationships with patients through greater understanding
455. Building and nurturing the therapeutic relationship
457. Seeing value in small but significant interactions

Integration into clinical practice
31. Putting ideas into practice
77. Linking psychological ideas in practice
78. Thinking and working more holistically
97. Thinking clinical meetings are possibly more thorough
98. Reflecting more openly in clinical meetings
200. Acting on the knowledge
230. Putting knowledge into practice
266. Carrying ideas into practice
356. Supervising ourselves outside the group
366. Becoming part of everyday practice
368. Transferring learning to the work place
418. Integrative practice
434. Using psychological models to inform practice

Observing positive impact on patients
87. Thinking that patients getting more positive outcomes
88. Noticing reducing self-harming behaviour
89. Patients talking more about positive changes
90. Witnessing changes in behaviour
92. Patients reporting positive feedback
103. Benefitting patients
277. Getting positive feedback from patients
332. Realising change is happening
351. Witnessing progress
373. Seeing positive impact on patients
396. Building rapport with staff??
432. Seeing more from the patient's perspective??
425. Reinforcing learnt theories??
440. Seeing patients responding positively and retaining the experience of different approaches from staff
444. Patients changing negative attitudes towards staff
450. Benefitting patients

D: IMPACT ON THE TEAM

Impacting on staff relationships
35. Getting support from group members
41. Reflecting build cohesion in the team
269. Benefits to staff interaction
274. Improving staff relations
374. Building trust amongst colleagues
466. Building staff morale

***19. Getting together as a group allows opportunity to know what others are doing**
96. Team cooperating with each other
275. Allowing more communication with each other
421. Keeping the group together
422. Getting insights into other's roles and theoretical frames of reference
442. Valuing each other's input with patients

***181. Talking and reflecting more as a team**
82. Staff discussing with staff
84. Reflecting openly with staff
85. Group stimulating open reflection
270. Reinforcing to each other what has been said in the group
271. Reminding each other of group discussions
384. Thinking more as a team

Team working

21. Learning from the experience of others
137. Feeling part of the team
164. Sharing the same feelings in the team
165. Not feeling alone with your thoughts
166. People having the same thoughts
242. Feeding from one another
264. Generating ideas off each other
265. Group provides opportunity to use each other's ideas
355. Working as a team
375. Experiencing positive impact on the team
395. Working from the same song sheet